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DHHM 16 Rev 6/95

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34502

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLAM LEE FULLER, SR.		2. Date of Death Month OCTOBER Day 31 Year 1996		3. Time of Death 03:50 PM
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER		4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 213-36-4415	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 26, 1936		9. Birthplace (State or Foreign Country) Washington, D.C.		
To Be Completed by Funeral Director	10e. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 1903 Hunt Meadows Drive		10f. Zip Code 21403		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate Agent		16b. Kind of Business/Industry Real Estate
	17. Father's Name (First, Middle, Last) Frank T. Fuller		18. Mother's Name (First, Middle, Maiden Surname) Ada K. Herbert		
	19a. Informant's Name/Relationship (Type, Print) Francis J. Fuller-Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12621 Heming Lane Bowie, Maryland 20716		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Cemetery 11/8/96 Annapolis, Maryland		
	21. Signature of Funeral Service Licensee <i>Donald A. Lytle</i>		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GUNSHOT WOUND OF CHEST				Approximate Interval Between Onset and Death
	Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
		Due to (or as a consequence of):			
		Due to (or as a consequence of):			
		Due to (or as a consequence of):			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 10-31-96		28b. Time of Injury 15:27 PM	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT WAS SHOT			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1903 Hunt Meadows Annapolis, Md			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.					
29b. Signature and title of certifier <i>Denise J. Chute</i>		29c. License number OCME		29d. Date signed (Month, Day, Year) NOVEMBER 01, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) NOV 08 1996		32. Registrar's Signature <i>Julia Davidson-Rendell</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34503

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Frances Van Gelder				2. Date of Death Month 10 Day 25 Year 96		3. Time of Death 1:45 PM																
	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester																
Funeral Director	5. Social Security Number 004-16-4895		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 6, 1918																
	9. Birthplace (State or Foreign Country) Mass.		10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury																
Usual Residence of Decedent																							
10e. Street and Number 6262 Ayreshire Drive				10f. Zip Code 21801		10g. Citizen of What Country? U.S.A.																	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Public School																
17. Father's Name (First, Middle, Last) John McLaughlin					18. Mother's Name (First, Middle, Maiden Surname) Bridget Barry																		
19a. Informant's Name/Relationship (Type, Print) Henry Van Gelder					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10																		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date 10/28		20c. Location - City or Town, State Hurlock, MD															
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility Bounds FH 705 E Main St Salisbury, MD 21801																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
<table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td style="width:50%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%;">a.</td> <td style="width:75%;">pneumonia</td> <td style="width:20%;">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>respiratory Failure</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>sick sinus syndrome</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> </td> <td style="width:25%; vertical-align: top;"> Approximate Interval Between Onset and Death 1 week 6 months 6 months </td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	<table border="0"> <tr> <td style="width:5%;">a.</td> <td style="width:75%;">pneumonia</td> <td style="width:20%;">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>respiratory Failure</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>sick sinus syndrome</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>	a.	pneumonia	Due to (or as a consequence of):	b.	respiratory Failure	Due to (or as a consequence of):	c.	sick sinus syndrome	Due to (or as a consequence of):	d.			Approximate Interval Between Onset and Death 1 week 6 months 6 months
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a.	pneumonia	Due to (or as a consequence of):																					
b.	respiratory Failure	Due to (or as a consequence of):																					
c.	sick sinus syndrome	Due to (or as a consequence of):																					
d.																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>[Signature]</i> physician			29c. License number H44283		29d. Date signed (Month, Day, Year) 10/25/96															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Durkin 9733 Healthway Drive Berlin, MD																							
31. Date filed (Month, Day, Year) OCT 29 1996			32. Registrar's Signature <i>[Signature]</i>																				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34504

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Arney Grubb

2. Date of Death

October 27 1996

3. Time of Death

11:10 AM

4a. Facility Name (If not institution, give street and number)

FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

213-18-0372

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 26, 1923

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

MD.

10b. County

WICOMICO

10c. City, Town or Location

WILLARDS

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7399 NEW HOPE ROAD

10f. Zip Code

21874

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year Dates: MARINE

WWII KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CONSTRUCTION SUPERVISOR

16b. Kind of Business/Industry

TELEPHONE CO.

17. Father's Name (First, Middle, Last)

JOHN DANIEL GRUBB

18. Mother's Name (First, Middle, Maiden Surname)

RUTH ARNEY

19a. Informant's Name/Relationship (Type, Print)

DONNA H. GRUBB

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7399 NEW HOPE RD., WILLARDS, MD. 21874

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

NEW HOPE CEMETERY

Date

10/31

20c. Location - City or Town, State

WILLARDS, MD.

21. Signature of Funeral Service Licensee

Gerald C. Bounds

22. Name and Address of Facility

BOUNDS FUNERAL HOME, SALISBURY, MD. 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

ASYSTOLE

Approximate
Interval Between
Onset and Death

1 MIN

a. Due to (or as a consequence of):

SEVERE CORONARY ART. DISEASE

26 yrs

b. Due to (or as a consequence of):

ARTERIO SCLEROSIS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital: ☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural
☐ Accident
☐ Suicide
☐ Homicide☐ Pending
investigation☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how Injury occurred

N/A.

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

N/A

29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Attending

29c. License number

D. 16444

29d. Date signed (Month, Day, Year)

OCT. 27th. 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIJAY S. NAIR M.D. 2112 BELAIR ROAD: FALLSTON: MD. 21047

31. Date filed (Month, Day, Year)

OCT 29 1996

Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34505

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sevrena Annette Godwin

2. Date of Death

Month Day Year
Oct. 15, 1996

3. Time of Death

19:46

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

221-86-6858

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

1

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2/16/1995

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Frankford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

PO Box 403

10f. Zip Code

19945

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

never employed

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

George S. Godwin

18. Mother's Name (First, Middle, Maiden Surname)

Evetta Briddell

19a. Informant's Name/Relationship (Type, Print)

George S. Godwin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 403, Frankford, Delaware 19945

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Curtis Cemetery

Date

10/19/96

20c. Location - City or Town, State

Bishopville, Md.

21. Signature of Funeral Service Licensee

Richard T. Watson

22. Name and Address of Facility

Watson Funeral Home, Millsboro, Delaware

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. multiple congenital cardiac anomalies

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

mental retardation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. CARLTON MD

29c. License number

D 44108

29d. Date signed (Month, Day, Year)

10-15-96

30. Name and address of person who completed cause of death (Item 28e) (Type, Print)

D. CARLTON MD / E.R. Atlantic General H. / Berlin, Md.

31. Date filed (Month, Day, Year)

OCT 24 1996

32. Registrar's Signature

John A. Davidson-Wardell

State
Registrar

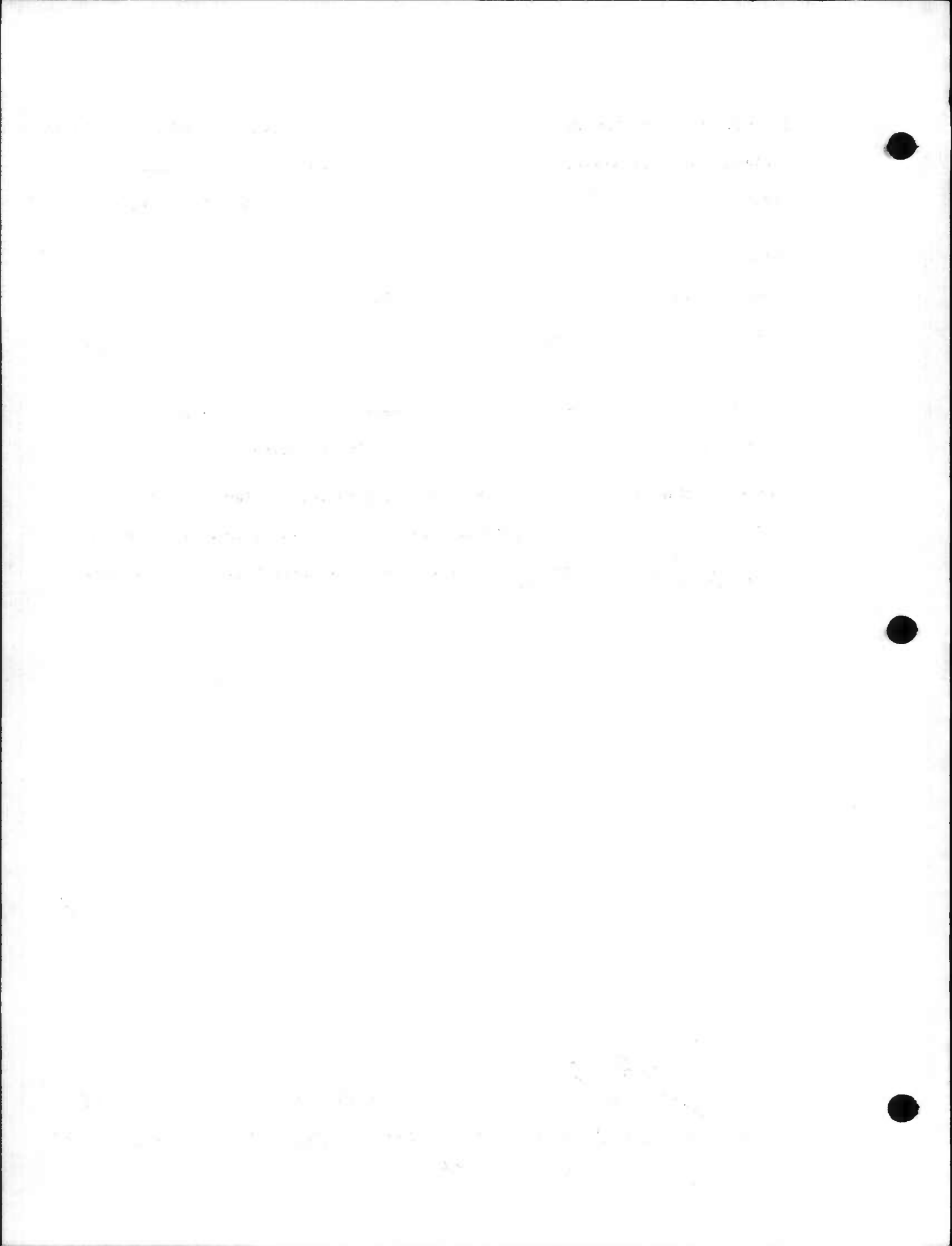
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34506

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID PATRICK GRIFFIN SR				2. Date of Death Month October Day 19 , Year 1996		3. Time of Death 6:10 AM														
	4a. Facility Name (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL				4b. City, Town, or Location of Death CAMBRIDGE		4c. County of Death DORCHESTER														
Funeral Director	5. Social Security Number 079-14-8474		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) July 12, 1920														
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury														
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1703 Eastgate Village, Apt. 107		10f. Zip Code 21804		10g. Citizen of What Country? USA														
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mason		16b. Kind of Business/Industry Brick Layer																
	17. Father's Name (First, Middle, Last) Thomas Michael Griffin				18. Mother's Name (First, Middle, Maiden Surname) Catherine Danaher																
	19a. Informant's Name/Relationship (Type, Print) Nancy M. Knapp/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 E. Upland Dr., Salisbury, MD 21801																
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State 10/21/96 Salisbury, MD																
	21. Signature of Funeral Service Licensee <i>David A. Womack</i> MO1051				22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>CORONARY ARTERY DISEASE</td> <td>Approximate Interval Between Onset and Death ~15yrs</td> </tr> <tr> <td>b.</td> <td>ANGINA</td> <td>~15yrs</td> </tr> <tr> <td>c.</td> <td>HTN</td> <td>UNKNOWN</td> </tr> <tr> <td>d.</td> <td>LEFT LOWER LOBE PNEUMONIA</td> <td>~10yrs</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CORONARY ARTERY DISEASE	Approximate Interval Between Onset and Death ~15yrs	b.	ANGINA	~15yrs	c.	HTN	UNKNOWN	d.	LEFT LOWER LOBE PNEUMONIA	~10yrs
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CORONARY ARTERY DISEASE	Approximate Interval Between Onset and Death ~15yrs																	
b.		ANGINA	~15yrs																		
c.		HTN	UNKNOWN																		
d.		LEFT LOWER LOBE PNEUMONIA	~10yrs																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CCPD																					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined																					
28a. Date of Injury (Month, Day, Year) N/A																					
28b. Time of Injury N/A																					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
28d. Describe how injury occurred N/A																					
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier <i>Raymond A. Parnell</i>																					
29c. License number 050271																					
29d. Date signed (Month, Day, Year) 10-19-96																					
30. Name and address of person who completed cause of death (from 23a) (Type, Print) RAYMOND A. PARNELL AND 503-A MAIN ST. CAMBRIDGE, MD 21613																					
31. Date filed (Month, Day, Year) OCT 22 1996																					
32. Registrar's Signature <i>John Davidson-Randall</i>																					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-387-0000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34507

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

CURTIS

GRAHAM

2. Date of Death

Month

Day

Year

November

2

1996

3. Time of Death

12:40 AM

4a. Facility Name (If not institution, give street and number)

PERRY POINT VETERANS HOSPITAL

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL COUNTY

5. Social Security Number

577-32-7711

6. Sex

M

20 F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year

NOV. 22 1928

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

364 SHETLAND SQUARE

10f. Zip Code

21061

10g. Citizen of What Country?

US

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: 1945-65

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

US NAVY

17. Father's Name (First, Middle, Last)

MAJOR GRAHAM

18. Mother's Name (First, Middle, Maiden Surname)

ADELLA B. KELLY

19a. Informant's Name/Relationship (Type, Print)

CARLA COOPER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

364 SHETLAND SQUARE GLEN BURNIE, MD. 21061

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NATIONAL CEME.

Date

11/6/96

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Harry B. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST STREET ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

28. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 OOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D32395

29d. Date signed (Month, Day, Year)

11/2/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THOMAS FINUCAN, M.D., VAMHCS Perry Point, MD 21902

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Sandra Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34508

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Stanley John Gresh | | | | 2. Date of Death
Month November Day 6 Year 1996 | | 3. Time of Death
8PM | |
| | 4a. Facility Name (If not institution, give street and number)
Meridian Health Care Center, Spa Creek | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
579-12-8672 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 28 1916 | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
1041 A Spa Road | | | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanic | | | 18b. Kind of Business/Industry
Auto | |
| 17. Father's Name (First, Middle, Last)
Andrew Gresh | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Kathryn Dudish | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret Elizabeth Gresh-Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1041 A Spa Road Annapolis, Maryland 21403 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Cemetery | | Date
11/11/96 | | 20c. Location - City or Town, State
Annapolis, Maryland |
| 21. Signature of Funeral Service Licenses
<i>[Signature]</i> | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Metastatic Adenocarcinoma | | | | | | | | Approximate Interval Between Onset and Death
Unknown |
| Immediate Cause (Final disease or condition resulting in death)
Due to (or as a consequence of): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | |
| 29c. License number
D30718 | | | | 29d. Date signed (Month, Day, Year)
November 7, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John D. Jackson, M.D. 2003 Medical Parkway Annapolis, Maryland 21401 (410-573-1110) | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 08 1996 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34509

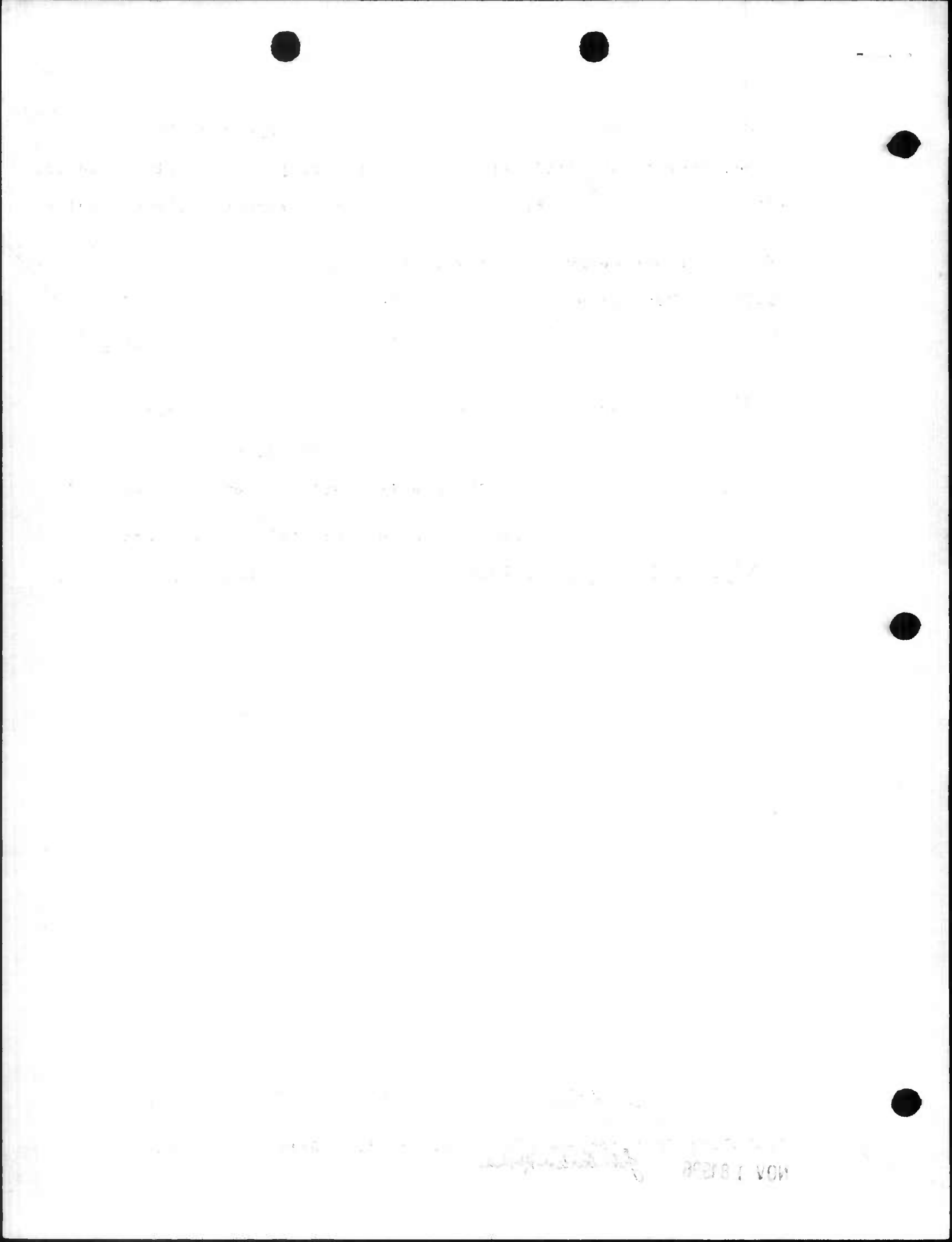
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BG GREENE | | | | 2. Date of Death
Month Day Year
August 22, 1996 | | 3. Time of Death
3 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital Center | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
N/A | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
N/A Yrs. | 8. Date of Birth (Month, Day, Year)
August 22, 1996 | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | 10. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Prince Georges | | 10c. City, Town or Location
Forestville | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
5841 Hil-Mar Drive | | 10f. Zip Code
20747 | | 10g. Citizen of What Country?
Maryland | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
N/A | | | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Terra Greene | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Terra Greene | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3001 Hospital Drive Cheverly, Maryland | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Prince Georges Hospital | | 20c. Location - City or Town, State
Cheverly | | | |
| | 21. Signature of Funeral Service Licensee
Robert H. Toehle, MD | | | | 22. Name and Address of Facility
Prince Georges Hospital Drive Cheverly MD | | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Respiratory Failure
Due to (or as a consequence of):
Hypoplastic Lungs
Due to (or as a consequence of):
Poss. Chromosomal Anomaly | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Possible Sepsis | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Isabelita Frattarolo MD | | | | 29c. License number
D27628 | | 29d. Date signed (Month, Day, Year)
11/5/96 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Isabelita Frattarolo M.D. 3001 Hospital Drive Cheverly, Md. | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
NOV 18 1996 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34510

| | | | | | |
|---|---|--|--|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HOWARD HILL | | 2. Date of Death
Month October Day 15 Year 1996 | | 3. Time of Death
4:00 PM |
| | 4a. Facility Name (If not institution, give street and number)
Salisbury Center/Genesis Eldercare | | 4b. City, Town, or Location of Death
Salisbury, MD | | 4c. County of Death
Wicomico |
| Funeral
Director | 5. Social Security Number
229-54-6663 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
1-18-1911 | | 9. Birthplace (State or Foreign Country)
Virginia | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Va | | 10b. County
Accomack |
| | 10c. City, Town or Location
Chincoteague | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
5077 Chicken City Rd. | | 10f. Zip Code
23336 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Waterman |
| | 16b. Kind of Business/Industry
Self | | 17. Father's Name (First, Middle, Last)
John W. Hill Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Betty Jones Hill |
| | 19e. Informant's Name/Relationship (Type, Print)
Ada M. Hill | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5077 Chicken City Rd., Chincoteague Va 23336 | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Downing Cemetery | | 20c. Location - City or Town, State
10-18-96 Oak Hall Va. |
| | 21. Signature of Funeral Service Licensee
Constance Salyer Gordon Bailey | | 22. Name and Address of Facility
6327 Church St Salyer F.H. Chincoteague Va 23336 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Emphysema
Due to (or as a consequence of):
c. Coronal Atherosclerosis
Due to (or as a consequence of):
d. | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | | |
| 28b. Time of Injury
M | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
William H. Robins, M.D. | | | | | |
| 29c. License number
029349 | | | | | |
| 29d. Date signed (Month, Day, Year)
10/16/96 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804 | | | | | |
| 31. Date filed (Month, Day, Year)
OCT 18 1996 | | | | | |
| 32. Registrar's Signature
John Davidson-Hardall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34511

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN MARIE HICKMAN

2. Date of Death

Month Day Year
OCT. 16 1996

3. Time of Death

7:10 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

829 ROGER STREET

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

213-22-8782

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAR. 12, 1931

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MD.

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

829 ROGER STREET

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

RECEPTIONIST

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

ELMAR S. CALLAHAN

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED SKINNER

19a. Informant's Name/Relationship (Type, Print)

ROBERT HICKMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

829 ROGER STREET, SALISBURY, MD. 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD. VETERAN'S CEMETERY

Date

10/21

20c. Location - City or Town, State

HURLOCK, MD.

21. Signature of Funeral Service Licensee

Donald C. Bounds

22. Name and Address of Facility

BOUNDS FUNERAL HOME, SALISBURY, MD. 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. LIVER FAILURE

Due to (or as a consequence of):

b. CHRONIC HEPATITIS C INFECTION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 months

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid Arthritis

DIABETES MELLITUS

PULMONARY FIBROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Allen W. Tustin, M.D.

29c. License number

D22996

29d. Date signed (Month, Day, Year)

Oct. 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen W. Tustin, M.D. 105 PINE BLUFF RD, SALISBURY, MARYLAND

31. Date filed (Month, Day, Year)

OCT 18 1996

32. Registrar's Signature

*John A. Randall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
202-343-2000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34512

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCE

HOLBROOK

2. Date of Death

Month Day Year
Oct. 21 1996

3. Time of Death

5:25 PM

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

216-18-8235

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 11 1900

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

Maryland Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

723 Olivia Street

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Will White

18. Mother's Name (First, Middle, Maiden Surname)

Delsia White

19a. Informant's Name/Relationship (Type, Print)

Annie Dashiell (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

723 Olivia St. Salisbury, Md. 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Springhill Mem. Gard.

Date

20c. Location - City or Town, State

Hebron, Md.

21. Signature of Funeral Service Licensee

Bladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home

821 West Rd. Salisbury, Md. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

e.

Pneumonia

Due to (or as a consequence of):

b.

Advanced Parkinson's

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

1 Day

years

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dysphagia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23 ☐24 ☐25 ☐26 ☐27 ☐28 ☐29 ☐30 ☐31 ☐32 ☐33 ☐34 ☐35 ☐36 ☐37 ☐38 ☐39 ☐40 ☐41 ☐42 ☐43 ☐44 ☐45 ☐46 ☐47 ☐48 ☐49 ☐50 ☐51 ☐52 ☐53 ☐54 ☐55 ☐56 ☐57 ☐58 ☐59 ☐60 ☐61 ☐62 ☐63 ☐64 ☐65 ☐66 ☐67 ☐68 ☐69 ☐70 ☐71 ☐72 ☐73 ☐74 ☐75 ☐76 ☐77 ☐78 ☐79 ☐80 ☐81 ☐82 ☐83 ☐84 ☐85 ☐86 ☐87 ☐88 ☐89 ☐90 ☐91 ☐92 ☐93 ☐94 ☐95 ☐96 ☐97 ☐98 ☐99 ☐100 ☐101 ☐102 ☐103 ☐104 ☐105 ☐106 ☐107 ☐108 ☐109 ☐110 ☐111 ☐112 ☐113 ☐114 ☐115 ☐116 ☐117 ☐118 ☐119 ☐120 ☐121 ☐122 ☐123 ☐124 ☐125 ☐126 ☐127 ☐128 ☐129 ☐130 ☐131 ☐132 ☐133 ☐134 ☐135 ☐136 ☐137 ☐138 ☐139 ☐140 ☐141 ☐142 ☐143 ☐144 ☐145 ☐146 ☐147 ☐148 ☐149 ☐150 ☐

151

96 34513

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
George Theodore Brown | | | | 2. DATE OF DEATH
MONTH DAY YEAR
October 16 1996 | | | | 3. TIME OF DEATH
1528 M | | | | | |
| 4. SOCIAL SECURITY NUMBER
214-32-5366 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
67 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
Feb. 8, 1929 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | | | 9c. COUNTY OF DEATH
WICOMICO | | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Salisbury | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
336 Whitman Avenue | | | | 10f. ZIP CODE
21801 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
African American | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +)
Md School for Blind | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | | | 16b. KIND OF BUSINESS/INDUSTRY
J. V. Wells | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Theodore Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Julia Holbrook | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mike Purkey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
110 Baptist Street - Salisbury, Maryland 21801 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Salisbury Crematory | | | | 20c. LOCATION — City or Town, State
Salisbury, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Patricia C. Jolley</i> | | | | 22. NAME AND ADDRESS OF FACILITY
1213 Jersey Road - Salisbury, Maryland 21801
Jolley Memorial Chapel | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetic Nephropathy
DUE TO (OR AS A CONSEQUENCE OF):
d. Diabetes Mellitus | | | | | | | | | | Approximate Interval Between Onset and Death
days
months
months
years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Ronald P. Trantz</i> | | | | | | 29c. LICENSE NUMBER
D36576 | | 29d. DATE SIGNED (Month, Day, Year)
10/16/96 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ronald P. Trantz M.D. 560 Riverside Dr. A204 Salisbury, Md. | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
OCT 22 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34514

| | | | | | | | | | | | | | | | | | |
|--|--|--------------------|---|--|---|--|--|--|---|----|------------------|---|----|--------------------|----|--|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOYCE May HUMPHREYS | | | | 2. Date of Death
Month Day Year
OCTOBER 30, 1996 | | 3. Time of Death
1:20 PM | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
100 Bertram Drive | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
219-40-8975 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
54 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 17 1942 | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Glen Burnie | | | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| | 10e. Street and Number
100 Bertram Drive | | | | 10f. Zip Code
21067 | | 10g. Citizen of What Country?
United States | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Kenneth Martin Stine | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mattie Brady | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Curtis C. Humphreys-Jr. Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 Bertram Drive Glen Burnie, Maryland 21067 | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Cemetery | | 20c. Location - City or Town, State
Annapolis, Maryland | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Ronald A. Lytle</i> | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Brain Metastases</td> <td rowspan="4">Approximate Interval Between Onset and Death
10 days
18 mo.</td> </tr> <tr> <td>b.</td> <td>Endometrial Cancer</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Brain Metastases | Approximate Interval Between Onset and Death
10 days
18 mo. | b. | Endometrial Cancer | c. | | d. |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Brain Metastases | Approximate Interval Between Onset and Death
10 days
18 mo. | | | | | | | | | | | | | | |
| | b. | Endometrial Cancer | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | | | | | | | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | | | | | | | | | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and Title of certifier
<i>Wm C Waterfield</i> | | | | | | | | | | | | | | | | | |
| 29c. License number
024356 | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
Oct. 31, 1996 | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
Wm. C. WATERFIELD MD 900 Caton Ave Balt Md 21229 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 01 1996 | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34515

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD W HYSAN, JR

2. Date of Death

OCTOBER 31 1996

3. Time of Death

11:25 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

579-40-9605

6. Sex

1 ☐ M 2 ☐ F
X

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

9-14-32

9. Birthplace (State or Foreign Country)

Washington DC.

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

195 Inverness Rd.

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Banker

16b. Kind of Business/Industry

Financial

17. Father's Name (First, Middle, Last)

Bernard W. Hysan Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Josephine Cameron

19a. Informant's Name/Relationship (Type, Print)

Bettie Hysan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

195 Inverness Rd. Severna Park MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Data

20c. Location - City or Town, State

11/2

Catonsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons Funeral Home

495 Ritchie Hwy Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE PARANSONS DISEASE

Due to (or as a consequence of):

UROSEPSIS

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

pneumonia

1 week

c. Due to (or as a consequence of):

1 week

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dan H. Schneibfeder MD

29c. License number

028221

29d. Date signed (Month, Day, Year)

OCTOBER 31, 1996

20. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN H. SCHNEIBFEDER, MD 301 HOSPITAL DRIVE GLEN BURNIE MARYLAND 21061

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34516

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Edward F Hunter

2. Date of Death
Month Day Year

November 2 1996

3. Time of Death

6AM

4a. Facility Name (If not institution, give street and number)

154 Prince George Street

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

142-50-1668

6. Sex

M F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 11 1932

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

154 Prince George Street

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 plus

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Training Officer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Edward William Hunter

18. Mother's Name (First, Middle, Maiden Summa)

Elizabeth I. Sharkey

19a. Informant's Name/Relationship (Type, Print)

Johnell A. Hunter-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

154 Prince George Street Annapolis, Maryland 21401

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Memorial Cemetery 11/6/96 Annapolis, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic cancer unknown primary

Approximate Interval Between Onset and Death

5 mos

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

019838

29d. Date signed (Month, Day, Year)

11/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart E. Selonick, M.D. 900 Bestgate Annapolis, Md. 21401

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34517

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Lillian Hetrick

2. Date of Death

November 4, 1996 9:30pm

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

834 Mago Vista Road

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

5. Social Security Number

166-30-0716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 6, 1935

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

834 Mago Vista Road

10f. Zip Code

21012

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Clarence Wetzel

18. Mother's Name (First, Middle, Maiden Surname)

Mary Dietrich

19a. Informant's Name/Relationship (Type, Print)

Mark Hetrick/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

834 Mago Vista Road, Arnold, MD 21012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

Nov. 5

1996

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Robert S. Taylor

22. Name and Address of Facility

Barranco and Sons Funeral Home 21146

495 Gov. Ritchie Hwy., Severna Park, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Coronary Artery Disease

3 years

Due to (or as a consequence of):

b. Congestive Heart Failure

3 years

Due to (or as a consequence of):

c. Diabetes Mellitus

10 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hip Fracture

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. J. Taylor

29c. License number

VA-0101-04981

29d. Date signed (Month, Day, Year)

Nov. 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen J. Taylor MD Walter Reed Army Medical Center, Washington DC

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34518

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CLARENCE SEYMOUR INGLIS | | | | | | 2. Date of Death
Month Day Year
NOV 4, 1996 | | 3. Time of Death
1030 AM | |
| | 4a. Facility Name (If not institution, give street and number)
CARROLL COUNTY GENERAL HOSPITAL | | | | | | 4b. City, Town, or Location of Death
WESTMINSTER | | 4c. County of Death
CARROLL | |
| Funeral
Director | 5. Social Security Number
215-10-5018 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN 25, 1913 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
CARROLL | | 10c. City, Town or Location
HAMPSTEAD | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1422 POPES CREEK DRIVE | | | | 10f. Zip Code
21074 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 2 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ACCOUNTANT | | | 16b. Kind of Business/Industry
STATE OF MARYLAND | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
CHARLES ATLEE INGLIS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH FABER | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
EDITH L. INGLIS, WIFE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1422 POPES CREEK DR, HAMPSTEAD, MD 21074 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKWOOD CEMETERY | | | Date
11/7 | | 20c. Location - City or Town, State
BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee
<i>Steven W. Eline</i> | | | 22. Name and Address of Facility
ELINE FUNERAL HOME
934 S MAIN ST, HAMPSTEAD, MD 21074 | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Pulmonary Aspiration
Due to (or as a consequence of):
Alzheimer's Dementia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
3 yrs | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
W.H. Foard MD | | | | 29c. License number
D02386 | | 29d. Date signed (Month, Day, Year)
11-5-96 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
WH Foard MD 3223 MAIN ST, MANCHESTER, MD 21102 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | 32. Registrar's Signature
<i>John D. ...</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34519

Certificate of Death

Reg. No.

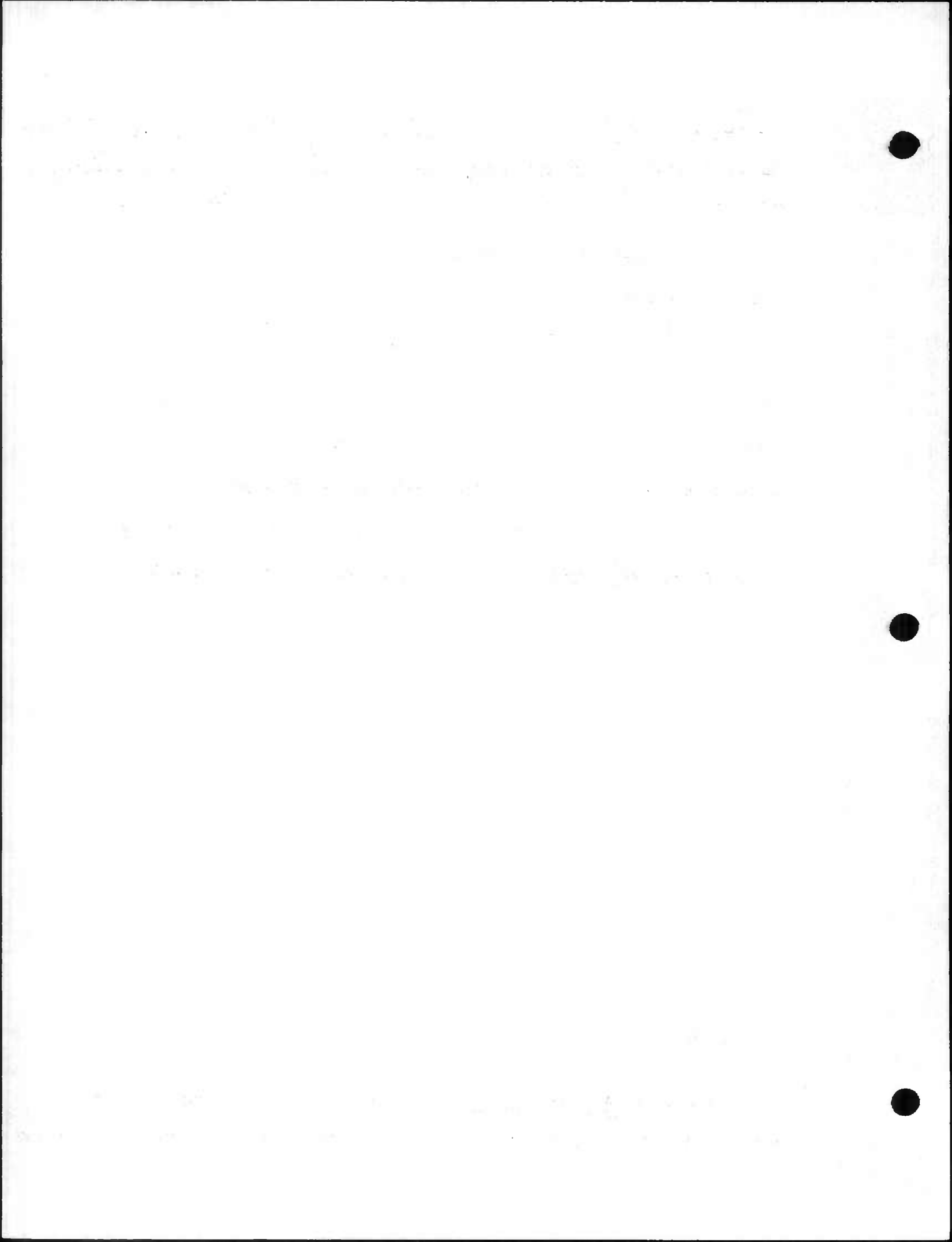
| | | | | | |
|--|--|---|--|--------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Joseph M Jones</i> | | 2. Date of Death
Month <i>November</i> Day <i>4</i> Year <i>1996</i> | | 3. Time of Death
<i>9:25 AM</i> |
| | 4a. Facility Name (If not institution, give street and number)
<i>Southern Maryland Hospital</i> | | 4b. City, Town, or Location of Death
<i>Clinton</i> | | 4c. County of Death
<i>Prince Georges</i> |
| Funeral
Director | 5. Social Security Number
<i>578-24-7044</i> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>88</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
<i>August 15, 1908</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
<i>Maryland</i> | 10b. County
<i>Prince George's</i> | 10c. City, Town or Location
<i>Aquasco</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
<i>21601 Aquasco Road</i> | | 10f. Zip Code
<i>20608</i> | | 10g. Citizen of What Country?
<i>USA</i> |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>5+</i> | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Farming</i> | | 16b. Kind of Business/Industry
<i>Agriculture</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>Harry Gross</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Nancy Jones</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Mamie Jones- Wife</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>21601 Aquasco Road Aquasco, Maryland 20608</i> | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Christ Church Cemetery November 8, 1996</i> | | 20c. Location - City or Town, State
<i>Aquasco, Maryland</i> |
| | 21. Signature of Funeral Service Licensee
<i>Lloyd M. Estep</i> | | 22. Name and Address of Facility
<i>Adams Funeral Home Aquasco, Maryland 20608</i> | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death |
| | a. <i>SEVERE MYOCARDIAL INFARCTION.</i> | | | | HOURS |
| | Due to (or as a consequence of): | | | | |
| | b. <i>ATHEROSCLEROTIC CORONARY HEART DISEASE</i> | | | | YEARS |
| | Due to (or as a consequence of): | | | | |
| | c. <i>REFRACTORY HYPOTENSION, CARDIOGENIC</i> | | | | HOURS |
| | Due to (or as a consequence of): | | | | |
| | d. <i>RENAL FAILURE DUE TO NO. 1</i> | | | | HOURS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>CANCER OF PROSTATE, MULTINFARCTION DEMENIA</i>
<i>CHRONIC ATRIAL FIBRILLATIONS</i>
<i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i> | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Peter W. Yim</i> | | 29c. License number
<i>D12884</i> | |
| 29d. Data signed (Month, Day, Year)
<i>NOV. 4 1996</i> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>PETER W. YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON MARYLAND 2073</i> | | | | | |
| 31. Date filed (Month, Day, Year)
<i>NOV 07 1996</i> | | 32. Registrar's Signature
<i>John Davidson Randall</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


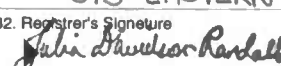
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34520

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KEVIN BLAKE JACKSON | | | | 2. Date of Death
Month Day Year
October 27, 1996 | | 3. Time of Death
4:15 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | |
| Funeral
Director | 5. Social Security Number | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
October 27, 1996 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Worcester | | 10c. City, Town or Location
Pocomoke City | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
3 Church Street | | | | 10f. Zip Code
21851 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
N/A | | |
| 17. Father's Name (First, Middle, Last)
Travue (nmn) Jackson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Susan Gloria Blake | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Susan G. Blake/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Church St., Pocomoke City, MD 21851 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory | | Date
10/29/96 | | 20c. Location - City or Town, State
Salisbury, MD | | |
| 21. Signature of Funeral Service Licensee
 MO1051 | | | | 22. Name and Address of Facility
Holloway Funeral Home
501 Snow Hill Rd., Salisbury, MD 21804 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Preterm labor, severe prematurity
Due to (or as a consequence of):
b. infarction of Placenta
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D45036 | | 29d. Date signed (Month, Day, Year)
10/29/96 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ELIZABETH PERNAL 813 EASTERN SHORE DR., SALISBURY, MD. 21804 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
OCT 29 1996 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

①

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34521

| | | | | | |
|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joseph Grant Keyhoe | | 2. Date of Death
Month July Day 19 Year 1996 | | 3. Time of Death
6:25AM |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery |
| Funeral
Director | 5. Social Security Number
577-34-2585 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Nov. 16, 1925 | | 9. Birthplace (State or Foreign Country)
Washington, DC | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda |
| | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
9914 Brixton Lane | | 10f. Zip Code
20817 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Korean War | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Program Analyst | | 16b. Kind of Business/Industry
U.S. Government |
| | 17. Father's Name (First, Middle, Last)
Donald S. Keyhoe | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Bishop | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary Frances Keyhoe/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9914 Brixton Lane, Bethesda, Maryland 20817 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | 20c. Location - City or Town, State
Silver Spring, MD |
| | 21. Signature of Funeral Service Licensee
Wade Perry M00803 | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
Pneumonia | | | | 7 days |
| | Due to (or as a consequence of):
Aspiration 2° to prior stroke | | | | 1 year |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
David A Holden MD | | 29c. License number
D47791 | | 29d. Date signed (Month, Day, Year)
July 19, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David A Holden MD 809 Veirs Mill, Rockville, MD 20851 | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1996 | | 32. Registrar's Signature
John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

CERTIFICATE MISS PLACE BY MONT CO. HEALTH DEPT. TALK TO MARGARET ABOUT THIS ON NOV. 14th RECEIVED CERTIFICATE ON
NOV. 18, 1996 REB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34522

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
JOHN R LEWIS | | | | 2. Date of Death
Month NOVEMBER Day 9 Year 1996 | | 3. Time of Death
2:45 AM | |
| 4a. Facility Name (If not institution, give street and number)
5617 OGDEN ROAD | | | | 4b. City, Town, or Location of Death
BETHESDA | | 4c. County of Death
MONTGOMERY | |
| 5. Social Security Number
470-18-3302 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT. 2, 1917 | |
| 9. Birthplace (State or Foreign Country)
ILLINOIS | | 10a. State
MARYLAND | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
BETHESDA | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
5617 OGDEN ROAD | | 10f. Zip Code
20816 | | 10g. Citizen of What Country?
UNITED STATES | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
GEOLOGIST | | 16b. Kind of Business/Industry
PETROLEUM | | 17. Father's Name (First, Middle, Last)
RALSTON LEWIS | |
| 18. Mother's Name (First, Middle, Maiden Surname)
VIRGINIA FOLKS | | 19a. Informant's Name/Relationship (Type, Print)
JULIA E. LEWIS, WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5617 OGDEN ROAD, BETHESDA, MD. 20816 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY | | 20c. Date
11/10/96 | | 20d. Location - City or Town, State
ALEXANDRIA, VA. | | 21. Signature of Funeral Service Licensee
Muriel H. Barber | |
| 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Metastatic Brain Cancer
Cancer of Prostate | | Approximate Interval Between Onset and Death
1 month
3 years | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 27. Date of Injury (Month, Day, Year)
NOV 18 1996 | | 27b. Time of Injury
M | | 27c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 27d. Describe how Injury occurred | | 27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 27f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
James J. Foster M.D. | | 29c. License number
204179 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 9, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES J. FOSTER M.D. 5530 Wisc. AV Chevy Chase Md 20815 | | 31. Date filed (Month, Day, Year)
NOV 18 1996 | | 32. Registrar's Signature
John A. Davidson-Randall | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34523

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNA LAURA LINDSAY | | | | 2. Date of Death
Month November Day 4 Year 1996 | | | | 3. Time of Death
7:42 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Carroll County General Hospital | | | | 4b. City, Town, or Location of Death
Westminster | | | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
214-16-0137 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth
(Month, Day, Year)
Aug. 16, 1918 | | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Westminster | |
| To Be Completed by
Funeral Director | Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
952 Deer Park Road | | 10f. Zip Code
21157 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
worker | | 16b. Kind of Business/Industry
Sewing Factory | | | | | |
| | 17. Father's Name (First, Middle, Last)
Elmer F. Logue | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie Bitzel | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
John E. Lindsay Sr., husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
952 Deer Park Rd., Westminster, MD 21157 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Deer Park Cemetery | | 20c. Location - City or Town, State
Westminster, MD | | | | | |
| | 21. Signature of Funeral Service Licensee
Katherine Peters-Sweitzer | | | | 22. Name and Address of Facility
Proctor Funeral Home & Chapel
412 Washington Rd., Westminster, MD 21157 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CEREBROVASCULAR ACCIDENT | | | | Approximate Interval Between Onset and Death
9 DAYS | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
SEPSIS
CONGESTIVE HEART FAILURE | | | | Due to (or as a consequence of):
3 DAYS
3 DAYS | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ATRIAL FIBILLATION | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
John H. Schaeffeler MD | | 29c. License number
028221 | | 29d. Date signed (Month, Day, Year)
November 4, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID SCHNEIDER, MD 200 MEMORIAL AVENUE WESTMINSTER MARYLAND | | | | 31. Data filed (Month, Day, Year)
NOV 06 1996 | | | | 32. Registrar's Signature
John Schneider-Randall
21157 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 34524

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CLIFFORD RAYMOND MORRIS | | | | 2. DATE OF DEATH
MONTH OCTOBER DAY 25 YEAR 1996 | | 3. TIME OF DEATH
0354 A | |
| 4. SOCIAL SECURITY NUMBER
214-30-8620 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
JAN 15, 1931 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| 10a. STATE
MD | | 10b. COUNTY
WICOMICO | | 10c. CITY, TOWN OR LOCATION
PARSONSBURG | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
32930 MT HERMON RD. | | | | 10f. ZIP CODE
21849 | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) SERVICE REPAIRMAN | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SERVICE REPAIRMAN | | 16b. KIND OF BUSINESS/INDUSTRY
T.V. CO. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
R. STANLEY MORRIS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MINNIE GORDY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JOAN A. MORRIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
32930 MT. HERMON RD., PARSONSBURG, MD. 21849 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
WANGO CEMETERY | | 20c. LOCATION — City or Town, State
10/27 WANGO, MD. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Gerald C. Bounds</i> | |
| 22. NAME AND ADDRESS OF FACILITY
BOUNDS FUNERAL HOME, SALISBURY, MD. | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
6 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
diabetes mellitus, hypertension | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Charles B. Silvia Jr MD</i> | | | | 29c. LICENSE NUMBER
D30853 | | 29d. DATE SIGNED (Month, Day, Year)
10/25/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles B. Silvia Jr MD 100 Power Street Salisbury MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
OCT 25 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34525

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT LOUIS MILLER

2. Date of Death

Month Day Year
10 18 96

3. Time of Death

20:03

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

068-07-3361

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

100

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 21, 1896

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

#1 Meadow Street

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW I13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11Collage (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

Telephone

17. Father's Name (First, Middle, Last)

Calvin Michael Miller

18. Mother's Name (First, Middle, Maiden Surname)

Blanche M. McPhillym

19a. Informant's Name/Relationship (Type, Print)

Robert Earl Miller/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5050 Falcon Ridge, Roanoke, Va 24014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Salisbury Crematory

Date

10/19/96

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

M01051

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert A. Duckert 4733 Healthway Drive Berlin, MD

State
Registrar

31. Date filed (Month, Day, Year)

OCT 21 1996

32. Registrar's Signature

John Davidson-Hardall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34526

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|--|---|---|--|---|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>John Earl Moore</u> | | | | 2. Date of Death
Month <u>October</u> Day <u>28</u> Year <u>1996</u> | | 3. Time of Death
<u>1815</u> | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Harford Memorial Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Havre de Grace</u> | | 4c. County of Death
<u>Harford</u> | | | | | | |
| Funeral
Director | 5. Social Security Number
<u>215-20-9867</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>70</u> Yrs. | If Under 1 Year
Months _____ Days _____ | If Under 24 Hrs.
Hours _____ Min. _____ | 8. Date of Birth (Month, Day, Year)
<u>Dec. 8, 1925</u> | | | | | | |
| | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | | | | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | | | | | | |
| | 10a. State
<u>Maryland</u> | | 10b. County
<u>Cecil</u> | | 10c. City, Town or Location
<u>Perryville</u> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number
<u>623 Charles Street</u> | | | | 10f. Zip Code
<u>21903</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <u>W.W.II</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: _____ | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>Twelve Years</u>
College (1-4 or 5+) _____ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Command Sgt. Major</u> | | 16b. Kind of Business/Industry
<u>Maryland Army National Guard</u> | | | | | | |
| | 17. Father's Name (First, Middle, Last)
<u>John Early Moore</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Mary Warrenfeltz</u> | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>Betty W. Moore (Wife)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>623 Charles Street, Perryville, Maryland 21903</u> | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Harford Memorial Gardens</u> | | Date
<u>10/31/96</u> | | 20c. Location - City or Town, State
<u>Aberdeen, Maryland</u> | | | | | | |
| | 21. Signature of Funeral Service Licensee
<u>Thomas M. Patterson, Sr.</u> | | | | 22. Name and Address of Facility
<u>Lee A. Patterson & Son Funeral Home</u>
<u>Perryville, Maryland 21903</u> | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>a. Squamous Carcinoma of Lung</u>
Due to (or as a consequence of):
<u>b. End Stage Chronic Obstructive Lung Disease</u>
Due to (or as a consequence of):
<u>c. Emphysema</u>
Due to (or as a consequence of):
<u>d. _____</u> | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
<u>10/29/96</u> | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>Hislop Gm mn</u> | | | | | | | | 29c. License number
<u>046412</u> | | 29d. Date signed (Month, Day, Year)
<u>10/29/96</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>319 S. Union Ave Harford DE</u> | | | | | | | | 31. Date filed (Month, Day, Year)
<u>OCT 31 1996</u> | | | | 32. Registrar's Signature
<u>Julia Wilson-Rendell</u> | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34527

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Vernon Arnold McMillan

2. Date of Death

Nov. 2, 1996

3. Time of Death

3:50 AM

4a. Facility Name (If not institution, give street and number)

Laurelwood Nursing Center

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

171-26-3556

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 10, 1935

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

De.

10b. County

New Castle

10c. City, Town or Location

Newark

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2771 Frenchtown Road

10f. Zip Code

19702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inspector Chrysler Corp.

16b. Kind of Business/Industry

Auto

17. Father's Name (First, Middle, Last)

Letcher M. McMillan

18. Mother's Name (First, Middle, Maiden Surname)

Ina Lily

19a. Informant's Name/Relationship (Type, Print)

Dolly Sue McMillan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2771 Frenchtown Rd., Newark, De. 19702

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris & Co.

Date

11/4/96

20c. Location - City or Town, State

West Chester, Pa.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

259 E. Main Street,
Gee Funeral Home Elkton, Md. 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Ca of Lung with metastasis

Due to (or as a consequence of):

b.

pneumonia

Due to (or as a consequence of):

c.

Fx of hip (Bone metastasis)

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

28. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?
☐ Yes ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Jm m Hawn MD

29c. License number

DC4823

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Twisha HS4 MD 223 W. MAIN ST ELKTON MD 21921

31. Date (Month, Day, Year)

Nov 4 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

mf
+9


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

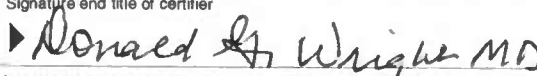

96 34528

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANTONIO ENRIQUE MARTINEZ-SAMAYOA | | | | | 2. Date of Death
Month Day Year
OCTOBER 26, 1996 | | | 3. Time of Death
1951PM | |
| | 4a. Facility Name (If not institution, give street and number)
1901 EAST WEST HIGHWAY #201 | | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
577-96-1011 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
43 Yrs. | | 8. Date of Birth (Month, Day, Year)
07/15/53 | | 9. Birthplace (State or Foreign Country)
Guatemala | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1901 East West Highway #201 | | | | 10f. Zip Code
20910 | | 10g. Citizen of What Country?
Guatemala | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Guatemalan | | | 14. Race - American Indian, Black, White, etc.
Specify: Hispanic | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mason | | | 16b. Kind of Business/Industry
Construction | | | |
| | 17. Father's Name (First, Middle, Last)
Manuel Martinez | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alejandra Samayoa | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Erwin Martinez (Brother) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
403 N Beauregard Street/Alexandria VA 22312 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant Valley | | | Date
10/31/96 | | 20c. Location - City or Town, State
Annandale, VA | |
| | 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
7211 Lee Highway Advent Funeral Services Falls Church, VA 22046 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Fatty liver
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
OCTOBER 27, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DONALD G WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 01 1996 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34529

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|---|--|------------------------|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Donald Maxwell | | | | | | 2. Date of Death
Month Day Year
October 31 1996 | | 3. Time of Death
4:30PM | |
| | 4a. Facility Name (If not institution, give street and number)
185 Woods Drive | | | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
157-24-8060 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec 19 1934 | | 9. Birthplace (State or Foreign Country)
New Jersey | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
185 Woods Drive | | | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5 plus | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Acoustical Engineer | | | 16b. Kind of Business/Industry
Engineering | | | |
| | 17. Father's Name (First, Middle, Last)
Harry P. Maxwell | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary D. Strang | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Barbara Maxwell | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
185 Woods Drive Annapolis, Maryland 21403 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Crematory | | | Date
11/4/96 | | 20c. Location - City or Town, State
Brentwood, Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE MYELOMA
Dua to (or as a consequence of):
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Approximate Interval Between Onset and Death
2 1/2 yrs | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | 29b. Signature and title of certifier
 | | 29c. License number
708118 | |
| | | | | | | | 29d. Date signed (Month, Day, Year)
11/11/96 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stanley P. Watkins, M.D. 900 Bestgate Road Annapolis, Maryland 21401 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34530

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES H. McEVoy | | | | 2. Date of Death
Month NOVEMBER Day 4 Year 1996 | | 3. Time of Death
1:15 PM | |
| | 4a. Facility Name (If not Institution, give street and number)
Genesis Eldercare-Spa Creek | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
580-01-7996 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
02/12/1917 | |
| | 9. Birthplace (State or Foreign Country)
England | | 10e. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
35 Milkshake Lane | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Boat Handler | | 16b. Kind of Business/Industry
Marine Industry | | | |
| | 17. Father's Name (First, Middle, Last)
Owen John McEvoy | | 18. Mother's Name (First, Middle, Maiden Surname)
Christina Hyland | | 19a. Informant's Name/Relationship (Type, Print)
Joan Leanos (Personal Rep.) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
716 Melvin Avenue/Annapolis MD 21401 | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Location - City or Town, State
Alexandria VA | | 20d. Date
11/05 | |
| | 21. Signature of Funeral Service Licensee
Melanie Wilkerson Hagon | | 22. Name and Address of Facility
Advent Funeral & Cremation Services
Annapolis MD 21401 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
METASTATIC PROSTATE CANCER | | Approximate Interval Between Onset and Death
14 YEARS | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier
John Davidson-Randall | | 29c. License number
D16354 | | 29d. Date signed (Month, Day, Year)
Nov. 4, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Enser W Cole 900 Bestgate Rd Annapolis MD 21401 | | 31. Date filed (Month, Day, Year)
NOV 07 1996 | | 32. Registrar's Signature
John Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34531

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NOREAN A. MOBRAY

2. Date of Death

Month Day Year
Oct 30 96

3. Time of Death

2134

4a. Facility Name (If not institution, give street and number)

Anne Arundel Gen. Hosp

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

AA

Funeral
Director

5. Social Security Number

579-35-2285

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

8. Date of Birth

Month Day Year

9. Birthplace (State or Foreign Country)

MARCH 19 1911

10. Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

930 PRESIDENT STREET APT. A1

10f. Zip Code

21403

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

BLACK

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

HARRY G. SIMMS

18. Mother's Name (First, Middle, Maiden Surname)

PEARL BOSTON

19a. Informant's Name/Relationship (Type, Print)

ELBERNYECE GLENN (NEICE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

930 PRESIDENT ST. APT. A 1 ANNAPOLIS, MD. 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS

Date

11/5/96

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Harry M. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiac Failure

b. Arteriosclerotic Heart Disease

c.

d.

Approximate Interval Between Onset and Death

UNK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deputy

29c. License number

D06054

29d. Date signed (Month, Day, Year)

10/30/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD

695 America

21035

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

John Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the top of the page, possibly a header or title.

Handwritten text in the upper middle section of the page.

Handwritten text in the middle section of the page.

Large block of handwritten text in the lower middle section of the page.

Handwritten text at the bottom of the page, possibly a footer or concluding remarks.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34532

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Keith Odom

2. Date of Death

Month Day Year
10 25 96

3. Time of Death

17:30

4a. Facility Name (If not institution, give street and number)

211 Walston Avenue

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

410-84-1737

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

44

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
03 12 52

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

211 Walston Avenue

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

steel worker

16b. Kind of Business/Industry

steel worker

17. Father's Name (First, Middle, Last)

Lane K. Odom, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Inez Wyatt Odom

19a. Informant's Name/Relationship (Type, Print)

Sean Eagler-Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 Walston Ave., Salisbury, MD 21804

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaks & Nichols Funeral Home

Date

10/29/96

20c. Location - City or Town, State

Columbia, TENN

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Road, Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Complications of AIDS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1104 Westbury Drive Salisbury MD 21804

31. Date filed (Month, Day, Year)

OCT 28 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34533

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD CARTER POWELL

2. Date of Death

November 5th 1996

3. Time of Death

6:35 AM

4a. Facility Name (If not institution, give street and number)

LIVINGSTON HEALTH CARE CENTER

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

265-01-5341

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 9 1906

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

ACCOKEEK

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

17710 INDIAN HEAD HIGHWAY

10f. Zip Code

20607

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WW 11

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TELEGRAPHIST

16b. Kind of Business/Industry

US GOVERNMENT

17. Father's Name (First, Middle, Last)

GEORGE E. POWELL

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE V. JENKINS POWELL

19a. Informant's Name/Relationship (Type, Print)

EDWARD GORDON POWELL (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1126 Apple Valley Road Accokeek, MD 20607

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

J.H. Eberwein Mortuary

4433 White Pls La White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer of Oral Cavity

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dehydration

Due to (or as a consequence of):

1 Month

dementia

Due to (or as a consequence of):

6 Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 24535

29d. Date signed (Month, Day, Year)

November 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAXMIN N. BERWA MD 7700 Old Branch Av. #101 Clinton, MD 20735

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

John Duckworth Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

96 34534

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Minnie Bell | | | | 2. DATE OF DEATH
MONTH October DAY 26 YEAR 1996 | | | | 3. TIME OF DEATH
1220 M | |
| 4. SOCIAL SECURITY NUMBER
219-42-8376 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 28, 1911 | | 8. BIRTHPLACE (State or Foreign Country)
SC | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | | | 9c. COUNTY OF DEATH
WICOMICO | |
| 10a. STATE
MD | | | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Eden | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
26590 Walnut Tree Road | | | | 10f. ZIP CODE
21822 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | 16b. KIND OF BUSINESS/INDUSTRY
Farming | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Williams | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maggie Williams | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Minnie L. Brooks | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7019 Yataruba Dr., SALISBURY Baltimore, MD 21207 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Green Acres Memorial | | DATE
11/02 | | 20c. LOCATION — City or Town, State
Salisbury, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 21801 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Hypertensive Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death
24 hrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Atrial Fibrillation | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Helen M. Baldado | | | | 29c. LICENSE NUMBER
D16840 | | 29d. DATE SIGNED (Month, Day, Year)
10/26/96 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Helen M. Baldado, 547KF Riverside Dr., Salisbury, MD 21801 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
OCT 28 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 34535

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY E. PHILLIPS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 20 1996 | | 3. TIME OF DEATH
1420 P M | |
| 4. SOCIAL SECURITY NUMBER
219-03-0147 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
February 1, 1915 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Salisbury | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
315 Naylor St. | | | | 10f. ZIP CODE
21804 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6
College (1-4 or 5+) — | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do not use retired.)
Housewife | | 18b. KIND OF BUSINESS/INDUSTRY
Domestic | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John K. Colona | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Daisey | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Donna Vernon/daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 86, Christmas, Florida 32709 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Salisbury Crematory | | DATE
10/21 | | 20c. LOCATION — City or Town, State
Salisbury, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>David A. Thompson</i> MO1051 | | | | 22. NAME AND ADDRESS OF FACILITY
Holloway Funeral Home
501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Cardiac Dysrhythmia</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. <i>Hypoxia</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. <i>CPD/CHF/Pneumonia</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Joseph Raffetto</i> | | | | 29c. LICENSE NUMBER
D20441 | | 29d. DATE SIGNED (Month, Day, Year)
10-21-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Joseph Raffetto 403 Conaway St. Salisbury, Md. 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
OCT 22 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Hardall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 34536

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
NANCY KAY PYSHER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
October 30, 1986 | | 3. TIME OF DEATH
7:10 A M | |
| 4. SOCIAL SECURITY NUMBER
218-34-2130 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
MAR. 4, 1938 | |
| 8. BIRTHPLACE (State or Foreign Country)
CHERRY HILL, MD | | | | 9a. FACILITY NAME (If not institution, give street and number)
371 TRINITY CHURCH ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH
NORTHEAST | |
| 9c. COUNTY OF DEATH
CECIL | | | | 10a. STATE
DE | | 10b. COUNTY
NEW CASTLE | |
| 10c. CITY, TOWN OR LOCATION
NEWARK | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
109 MULBERRY RD. | |
| 10f. ZIP CODE
19711 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SENIOR SECRETARY | | 16b. KIND OF BUSINESS/INDUSTRY
EDUCATION | |
| 17. FATHER'S NAME (First, Middle, Last)
CHARLES L. SPROUT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ROSELYN SYKES | | | |
| 19a. INFORMANT'S NAME (Type/Print)
GLENWOOD V. PYSHER (HUSBAND) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
109 MULBERRY RD., NEWARK, DE 19711 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
LAWN CROFT CEMETERY CREMATION SERVICE 10/31/96 LINWOOD, PA | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Donald S. Hicks</i> | | | | 22. NAME AND ADDRESS OF FACILITY
HICKS HOME FOR FUNERALS, 103 W. STOCKTON ST. ELKTON, MD 21921 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Glioblastoma of brain
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>H. Farkas, MD</i> | | | | 29c. LICENSE NUMBER
D15314 | | 29d. DATE SIGNED (Month, Day, Year)
October 30, 1986 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
H Farkas, MD, 239 S Bridge St. Northern Chesapeake Hospice, E Elkton, MD 21921 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 01 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Film G751 item 3 per PH 11-13-96 rja

Certificate of Death

Reg. No.

96 34537

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fred Willard Rodeheaver

2. Date of Death

Month Day Year
Oct. 15, 1996

3. Time of Death

22:10

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Garrett County Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

233-42-7974

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 3, 1921

9. Birthplace (State or Foreign Country)

Hazelton, WV

Usual Residence of Decedent

10a. State

WV

10b. County

Preston

10c. City, Town or Location

Bruceton Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 3 Box 209

10f. Zip Code

26525

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942 & 194313. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Timberman

16b. Kind of Business/Industry

Forestry

17. Father's Name (First, Middle, Last)

Hamon Rodeheaver

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Reckart Rodeheaver

19a. Informant's Name/Relationship (Type, Print)

James Rodeheaver

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

651 Faulkner Ave. Martinsburg, WV 25401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parnell Cemetery

Date

10/18/96 Cuzzart, WV

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Arthur H. Wright

22. Name and Address of Facility Browning Funeral Home, Inc.

201 E. Main St. Kingwood, WV 26537

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

metastatic adenocarcinoma

Approximate
Interval Between
Onset and Death

6 months

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

TH

29c. License number

D15233

29d. Date signed (Month, Day, Year)

10/21/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550

31. Date filed (Month, Day, Year)

NOV 13 1996

32. Registrar's Signature

Richard R. Rodeheaver

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NOV 13 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34538

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|--|--|---|---------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Norris H Robertson | | | | 2. Date of Death
Month: 10 Day: 26 Year: 1996 | | | 3. Time of Death
1350h | |
| | 4a. Facility Name (If not institution, give street and number)
209 Maple Way | | | | 4b. City, Town, or Location of Death
Salisbury | | | 4c. County of Death
Wicomico | |
| Funeral
Director | 5. Social Security Number
214-10-9258 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months: Days: | If Under 24 Hrs.
Hours: Min. | 8. Date of Birth (Month, Day, Year)
Apr 27, 1914 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Salisbury | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
104 East Lincoln Avenue | | | | 10f. Zip Code
21804 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII Army | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9 College (1-4 or 5+): | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sales Clerk | | 16b. Kind of Business/Industry
Hardware Store | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Harlan H Robertson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Verna Coulbourn | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Richard Parsons | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
209 Maple Way Salisbury, Maryland 21804 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parsons Cemetery | | Date
10/29 | | 20c. Location - City or Town, State
Salisbury, Maryland | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Bounds FH 705 E Main St Salisbury, MD | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. congestive heart failure
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
10mo. |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
right and left pleural effusions
chronic obstructive pulmonary disease
coronary artery disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Rodney A. Wenrich M.D. | | 29c. License number
D15384 | | 29d. Date signed (Month, Day, Year)
10-28-96 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RODNEY A. WENRICH 100 POWER ST. SALISBURY Md. 21804 | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
OCT 29 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34539

Reg. No.

| | | | | | | | | | | |
|---|--|-------------------------|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM ALLEN ROYAL JR. | | | | | 2. Date of Death
Month Day Year
10- 17 96 | | 3. Time of Death
3:45 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
WATER VIEW HEALTHCARE CENTER | | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
223-52-9835 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
56 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
9 4 1940 | | 9. Birthplace (State or Foreign Country)
BRACY, VA. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | 10b. County
WICOMICO | | 10c. City, Town or Location
FRUITLAND | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
109 POPLAR STREET | | | | 10f. Zip Code
21826 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 yrs College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | | 16b. Kind of Business/Industry
CHEF | | | |
| | 17. Father's Name (First, Middle, Last)
WILLIAM ALLEN ROYAL, SR. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
GLADYS LEE WILLIAMS | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
DURRELL DASHIELD | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
220 COULBOURNE MILL ROAD, SALISBURY, MD. 21801 | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SALISBURY CREMATORY | | Date | | 20c. Location - City or Town, State
SALISBURY, MD. 21801 | | | |
| | 21. Signature of Funeral Service Licensee
<i>Loretta B. Jolley</i> | | | | 22. Name and Address of Facility
JOLLEY MEMORIAL CHAPEL,
1213 JERSEY ROAD, SALISBURY, MD. 21801 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
a. Lung cancer
b. Coronary artery disease
c. Congestive heart failure
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death
20-24 yrs
yes
yes | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
029349 | | 29d. Date signed (Month, Day, Year)
10/18/96 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William A. Robbins M.D. Rt. 50 & E. Main Street, Salisbury, MD 21801 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
Oct 28 1996 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 34540

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARIE H. ROSS | | | | 2. DATE OF DEATH
MONTH October DAY 23 YEAR 1996 | | | | 3. TIME OF DEATH
1205 M | |
| 4. SOCIAL SECURITY NUMBER
170-26-4436 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
Sept. 20, 1913 | | 8. BIRTHPLACE (State or Foreign Country)
Pa. | |
| 9a. FACILITY NAME (If not Institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | | 9c. COUNTY OF DEATH
WICOMICO | | |
| 10a. STATE
Md. | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Delmar | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
605 Elizabeth St. | | | | 10f. ZIP CODE
21875 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Seamstress | | | 16b. KIND OF BUSINESS/INDUSTRY
Garment Co. | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Krenciglova | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elizabeth Rentovich | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sharon Ross-Comba | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
605 Elizabeth St. Delmar, Md. 21875 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Stephens Cemetery | | | DATE
10-26 | 20c. LOCATION — City or Town, State
Delmar, DE. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>William M. Hoff</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Short Funeral Home, Inc.
13 E. Grove St. Delmar, De. 19940 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multi System failure
Approximate Interval Between Onset and Death 3 day
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
<div style="display: flex; justify-content: space-between;"> <div> a. DUE TO (OR AS A CONSEQUENCE OF):
 b. DUE TO (OR AS A CONSEQUENCE OF): Sepsis due to MRSA stage 1 ch
 c. DUE TO (OR AS A CONSEQUENCE OF): Recurrent esp pneumonia
 d. </div> <div> 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO </div> </div> | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>J. M. Sp... M.D.</i> | | | | 29c. LICENSE NUMBER
D48221 | | 29d. DATE SIGNED (Month, Day, Year)
10/23/96 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. M. Sp... M.D. 262 Tilghman Rd. Salisbury MD 21801 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
OCT 28 1996 | | 32. REGISTRAR'S SIGNATURE
<i>Jane Davidson Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34541

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN MARIE

SIEGEL

2. Date of Death

Month Day Year
OCTOBER 17, 1996

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

558-28-5907

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
07 18 11

9. Birthplace (State or Foreign Country)

Los Angeles, CA

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

200 Civic Ave., %Salisbury Center

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Otto A. Larson

18. Mother's Name (First, Middle, Maiden Surname)

Florence (?) Hank

19a. Informant's Name/Relationship (Type, Print)

James R. Siegel

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

722 Burning Tree Circle, Salisbury, MD 21801

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Eternal Hills Mem. Pk.

Date

10/20/96

20c. Location - City or Town, State

OCEANSIDE, CA

21. Signature of Funeral Service Licensee

MO1051

22. Name and Address of Facility

Holloway Funeral Home, P.A.

501 Snow Hill Road, Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Demencia*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. *Old COPD*
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

yrs
yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No25. Was case referred to medical examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-29349

29d. Date signed (Month, Day, Year)

11/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

31. Date filed (Month, Day, Year)

OCT 18 1996

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

96 34542

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Charles Preston Shockley | | | | 2. DATE OF DEATH
MONTH October DAY 13 YEAR 1996 | | 3. TIME OF DEATH
1720 M | |
| 4. SOCIAL SECURITY NUMBER
18-30-1052 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
April 30, 1924 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Newark | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
8629 Tindleytown Road | | | | 10f. ZIP CODE
21841 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
African American | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
5th | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
laborer | | 16b. KIND OF BUSINESS/INDUSTRY
Bounds Sand & Gravel | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Shockley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Bethard | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Don Jose' Shockley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3256 Roswell Drive - Columbus, OH 43227 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Calvary UM Church Cem. 10/19 Berlin, Maryland | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Patricia A. Jolley</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Jolley Memorial Chapel Maryland 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Chronic Obstructive Pulmonary Disease | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Cor Pulmonale | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Right Heart Failure | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. Pneumonia | | | | | | | |
| Approximate interval Between Onset and Death
20 yrs | | | | | | | |
| Approximate interval Between Onset and Death
2 wks | | | | | | | |
| Approximate interval Between Onset and Death
2 wks | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Christopher S. Snyder D.O.</i> | | | | 29c. LICENSE NUMBER
H50497 | | 29d. DATE SIGNED (Month, Day, Year)
10/14/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Christopher S. Snyder D.O. 110 E. Carroll St. Salisbury, MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
OCT 22 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

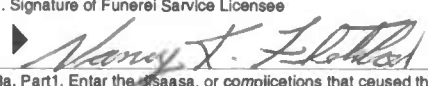
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


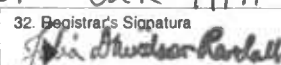
State of Maryland / Department of Health and Mental Hygiene

96 34543

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE McCLELLAN SHATZER | | | | 2. Date of Death
Month November Day 3 Year 1996 | | 3. Time of Death
2245 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number)
WASHINGTON COUNTY HOSPITAL | | | | 4b. City, Town, or Location of Death
HAGERSTOWN | | 4c. County of Death
WASHINGTON | | |
| Funeral
Director | 5. Social Security Number
217-28-1417 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
62 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
MAY 30, 1934 | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
W. VA. | | 10b. County
BERKELEY | | 10c. City, Town or Location
FALLING WATERS | | | 10d. Inside City Limits
1 Yes 2 No | |
| | 10e. Street and Number
P.O. BOX 10, SPORTSMAN PARADISE | | | | 10f. Zip Code
25419 | | 10g. Citizen of What Country?
USA. | | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: NAVY | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PLUMBER | | 16b. Kind of Business/Industry
CONSTRUCTION | | | | |
| | 17. Father's Name (First, Middle, Last)
HAROLD BRUCE SHATZER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ALICE THOMAS | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
MARY E. SHATZER - WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 10, FALLING WATERS, WEST VIRGINIA | | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD. VETERANS CEM. 11/8/96 | | 20c. Location - City or Town, State
OWINGS MILLS, MD. | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
FLETCHER FUNERAL HOME
254 EAST MAIN ST. WESTMINSTER, MD. 21157 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Atrial Fibrillation
Due to (or as a consequence of):
b. Myocardial Infarction
Due to (or as a consequence of):
c. Coronary Artery Disease
Due to (or as a consequence of):
d. | | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death
40 Minutes
4 days
Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 MD | | 29c. License number
D. 47288 | | 29d. Date signed (Month, Day, Year)
Nov. 4, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. T. G. Ball 1610 Oak Hill Ave. Hagerstown, MD 21742 | | | | | | | | | |
| 31. Date filed (Month/Day, Year)
NOV 07 1996 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

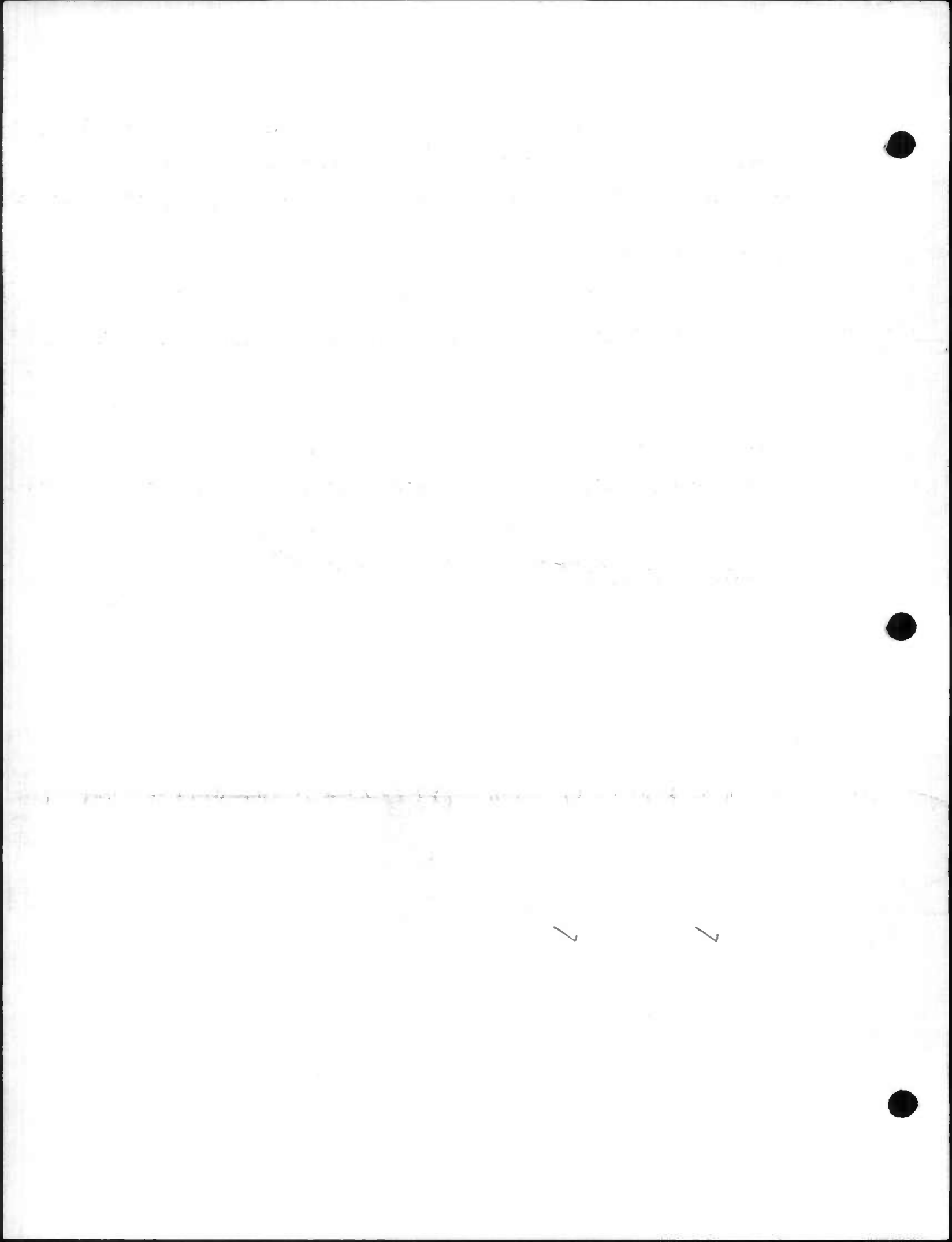
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34544

| | | | | | | | | | |
|--|---|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELIZABETH SUMMERS | | | | 2. Date of Death
Month NOVEMBER Day 4 , Year 1996 | | 3. Time of Death
7:14 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death | | |
| Funeral
Director | 5. Social Security Number
215-42-7900 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 3, 1919 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Carroll | | 10c. City, Town or Location
Westminster | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
66 D. South Church Street | | | 10f. Zip Code
21157 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
worker | | 16b. Kind of Business/Industry
college | | | | |
| | 17. Father's Name (First, Middle, Last)
George Bowens Hall | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Dorsey | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Maryln Summers, son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
66 D South Church Street, Westminster, MD 21157 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Strawbridge Church Cemetery | | 20c. Location - City or Town, State
New Windsor, MD | | | | |
| | 21. Signature of Funeral Service Licensee
Katherine Pritts - Switzer | | | | 22. Name and Address of Facility
Pritts Funeral Home & Chapel
412 Washington Rd., Westminster, MD | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):
b. Aortic Insufficiency
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
10 years
2 years
20 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Seizure disorder, Sick Sinus Syndrome | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Matthew L Kashira | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
November 4, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATTHEW L KASHIRA Johns Hopkins Hospital Baltimore Maryland, | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 06 1996 | | 32. Registrar's Signature
John A. Randall | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34545

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert W. Speaker

2. Date of Death

Month Day Year
October 31 1996

3. Time of Death

7:10pm

4a. Facility Name (If not institution, give street and number)

1117 Little Magothy View

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

578-42-6641

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2/27/32

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1117 Little Magothy View

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Shop Specialist

16b. Kind of Business/Industry

Power Co.

17. Father's Name (First, Middle, Last)

George Speaker

18. Mother's Name (First, Middle, Maiden Summa)

Edna Hayden

19a. Informant's Name/Relationship (Type, Print)

Barbara Speaker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1117 Little Magothy View Annapolis MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

11/5

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons Funeral Home
495 Ritchie Hwy Severna Park MD 21146

23a. Pertinent: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Brain tumor

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D29571

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1655 Crofton Boulevard Suite 101 Crofton MD 21114

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-5055.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34546

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Louis Smith

2. Date of Death
Month Day Year

November 6 1996

3. Time of Death
Hour Minute

10:45AM

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

329-09-3365

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Nov 15 1912

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7708 Frederick Road

10f. Zip Code

20784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Printing Specialist

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

William Edward Smith

18. Mother's Name (First, Middle, Maiden Sumama)

Allie Bowden

19a. Informant's Name/Relationship (Type, Print)

Wilma A. Smith-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7708 Frederick Road Hyattsville, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Lincoln Cemetery 11/9/96

Date

20c. Location - City or Town, State

Brentwood, Maryland

Signature of Funeral Service Licensee

Daniel L. Lytle

22. Name and Address of Facility

Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd. Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. CEREBRAL INFARCT.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTI INFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

K. J. Mathew

29c. License number

014799

29d. Date signed (Month, Day, Year)

11/8/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. J. MATHEW 6510 Kenilworth Ave. Riverdale, Md.

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

96 34547

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|-----------------------------------|---|---|-------------------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
DORIS RAE TWILLEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
October 22 1996 | | | | 3. TIME OF DEATH
2250 P M | | | | |
| 4. SOCIAL SECURITY NUMBER
213-24-0458 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
68 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 29, 1928 | | 8. BIRTHPLACE (State or Foreign Country)
DE. | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | | 9c. COUNTY OF DEATH
WICOMICO | | | | | |
| 10a. STATE
De. | | 10b. COUNTY
Sussex | | 10c. CITY, TOWN OR LOCATION
Delmar | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
88 Golden Lane | | | | 10f. ZIP CODE
19940 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Cook | | | 16b. KIND OF BUSINESS/INDUSTRY
Restaurant | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Raymond Smith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Iva Truitt Smith | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Phyllis T. Crouch | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1 Box 523 AA Delmar, DE. 19940 | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
Springhill Memory Gardens 10-26 | | | 20c. LOCATION — City or Town, State
Hebron, Md. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>William M. Short</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Short Funeral Home, Inc.
13 e. Grove St. Delmar, De. 19940 | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Breast cancer</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Hypertension</i>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | Approximate Interval Between Onset and Death
yrs.
yrs. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William Robins, M.D.</i> | 29c. LICENSE NUMBER
229349 | 29d. DATE SIGNED (Month, Day, Year)
10/23/96 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William Robins, M.D. 1104 HEATHWAY DR. SALISBURY, MD 21801 | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
OCT 28 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34548

| | | | | | | | | |
|--|--|--|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDWARD ROSS TRAYNOR, JR. | | | | 2. Date of Death
Month Day Year
NOV. 3, 1996 | | 3. Time of Death
6:50 PM | |
| | 4a. Facility Name (If not institution, give street and number)
LONG VIEW NURSING HOME | | | | 4b. City, Town, or Location of Death
MANCHESTER | | 4c. County of Death
CARROLL | |
| Funeral
Director | 5. Social Security Number
212-20-4819 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
7/24/1926 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | 10a. State
MD. | | 10b. County
BALTIMORE | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
1808 WENTWORTH RD. | | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
USA. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
TOOL & DIE MAKER | | 16b. Kind of Business/Industry
MANUFACTURING | | | |
| | 17. Father's Name (First, Middle, Last)
EDWARD ROSS TRAYNOR, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ADA E. | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
EDWARD R. TRAYNOR - NEPHEW | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
27 GREENVALE RD., WESTMINSTER, MD. 21157 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOODLAWN CEMETERY 11/6/96 | | 20c. Location - City or Town, State
WOODLAWN, MD. | | | |
| | 21. Signature of Funeral Service Director | | | | 22. Name and Address of Facility
FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | |
| | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic carcinoma Primary uncertain months
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number
D33/65 | | 29d. Date signed (Month, Day, Year)
11/4/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Steffer 2111 Honour Pike Hampstead md 21074 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 06 1996 | | | | 32. Registrar's Signature
John Devolker Randall | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34549

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mable K. Vaughn | | 2. Date of Death
Month Day Year
July 19, 1996 | | 3. Time of Death
2:15 AM |
| | 4a. Facility Name (If not institution, give street and number)
Alegis-Bethesda | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery |
| Funeral
Director | 5. Social Security Number
578-34-1718 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
June 26, 1921 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville |
| | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
14635 Bauer Drive #207 | | 10f. Zip Code
20853 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | 16b. Kind of Business/Industry
Dry Cleaning |
| | 17. Father's Name (First, Middle, Last)
John Henry Sullivan | | 18. Mother's Name (First, Middle, Maiden Surname)
Agnes Louise Cooley | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Bernard L. Vaughn/ Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10468 La Grant Lane Culpeper, Virginia 22701 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
Brentwood, Maryland |
| | 21. Signature of Funeral Service Licensee
M00335 | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
Guillian Barre Syndrome | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Lung Disease
Sepsis, Aspiration | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| State Registrar | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier
Elliot R. Goldstein | | 29c. License number
D03581 | | 29d. Date signed (Month, Day, Year)
July 19, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Elliot R. Goldstein, M.D., 9410 Old Georgetown Road, Bethesda, Maryland 20814 | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1996 | | 32. Registrar's Signature
John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

CERTIFICATE MISS PLACE BY MONT. CO. HEALTH DEPT. TALK TO MARGARET ABOUT THIS ON NOV. 14th RECEIVED CERTIFICATE
ON NOV. 18, 1996 REB

96 34550

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
June Cosby WILLIAMS | | | | 2. DATE OF DEATH
MONTH 10 DAY 20 YEAR 96 | | 3. TIME OF DEATH
8:35 P.M. | |
| 4. SOCIAL SECURITY NUMBER
230-52-7343 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12/15/30 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | 9. COUNTY OF DEATH
WICOMICO | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
4358 SUNSET DR TYASKIN MD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
TYASKIN | | 9c. COUNTY OF DEATH
WICOMICO | |
| 10a. STATE
MD | | 10b. COUNTY
WICOMICO | | 10c. CITY, TOWN OR LOCATION
TYASKIN | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
4358 SUNSET DR | | | | 10f. ZIP CODE
21865 | | 10g. CITIZEN OF WHAT COUNTRY?
US | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Deputy Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Accomack County General District Court | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Dr. William Lee Cosby | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Amine Cobb | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Darrell E. Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4358 Sunset Dr., Tyaskin, Md. 21865 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Cape Charles Cemetery | | 20c. LOCATION — City or Town, State
Cape Charles, Va. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Doughty Funeral Home, Inc.
P.O. Box 633, Exmore, Va. 23350 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | Approximate Interval Between Onset and Death
2 yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
_____ | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Stephen H. Lafey MD</i> | | | | 29c. LICENSE NUMBER
D20683 | | 29d. DATE SIGNED (Month, Day, Year)
10/21/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
STEPHEN H. LAFFEY MD DO Box 121 NANTICOKE MD 21840 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
OCT 29 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34551
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jake F. Walker, JR.

2. Date of Death
Month Day Year

November 04 1996

3. Time of Death

11:44AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Wicomico Nursing Home

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

218-14-1227

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

06/01/1924

9. Birthplace (State or Foreign
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

APT. c-111 RIVERSIDE DRIVE

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

GAS STATION

17. Father's Name (First, Middle, Last)

JAKE F. WALKER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

JENNIE BURKE

19a. Informant's Name/Relationship (Type, Print)

SARAH GRANT/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 LAKEWOOD DRIVE, SALISBURY, MD. 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ALL SAINTS MONIE CEMETERY


Date

11/06

20c. Location - City or Town, State

VENTON, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HINMAN FUNERAL HOME

MO0295

11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute myocardial inf.

6 h.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Age

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD + Emphysema -> Smoking

Oxygenation - Coronary

by Pass -

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D02026

29d. Date signed (Month, Day, Year)

NOV - 5 - 96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

F.G. Arthes, MD. 1622 A Ocean Pines, Berlin, Md. 21811

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

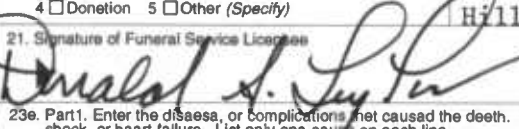
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death


Reg. No.

96 34552

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
James A Wheeler | | | | 2. Date of Death
Month Day Year
October 30 1996 | | 3. Time of Death
2:30PM | |
| 4a. Facility Name (If not Institution, give street and number)
5 South Cherry Grove Avenue | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| 5. Social Security Number
216-18-5982 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug 16 1910 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
5 South Cherry Grove Avenue | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Civil Service Worker | | 16b. Kind of Business/Industry
United States Government (Retired) | | | |
| 17. Father's Name (First, Middle, Last)
John Wheeler | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Katherine Carolyn Lewis | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James R. Wheeler-Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 South Cherry Grove Avenue Annapolis, MD 21401 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Cemetery | | 20c. Location - City or Town, State
Annapolis, Maryland | | 20d. Date
11/2/96 | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, Maryland | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Coronary atherosclerosis
Due to (or as a consequence of):
b. Cerebral aneurysm
Due to (or as a consequence of):
c. Cerebral aneurysm
Due to (or as a consequence of):
d. Cerebral aneurysm | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D05259 | | 29d. Date signed (Month, Day, Year)
October 31, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John Hedeman, M.D. 1407 Forest Drive Annapolis, Maryland 21403(410-267-8684) | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 01 1996 | | | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

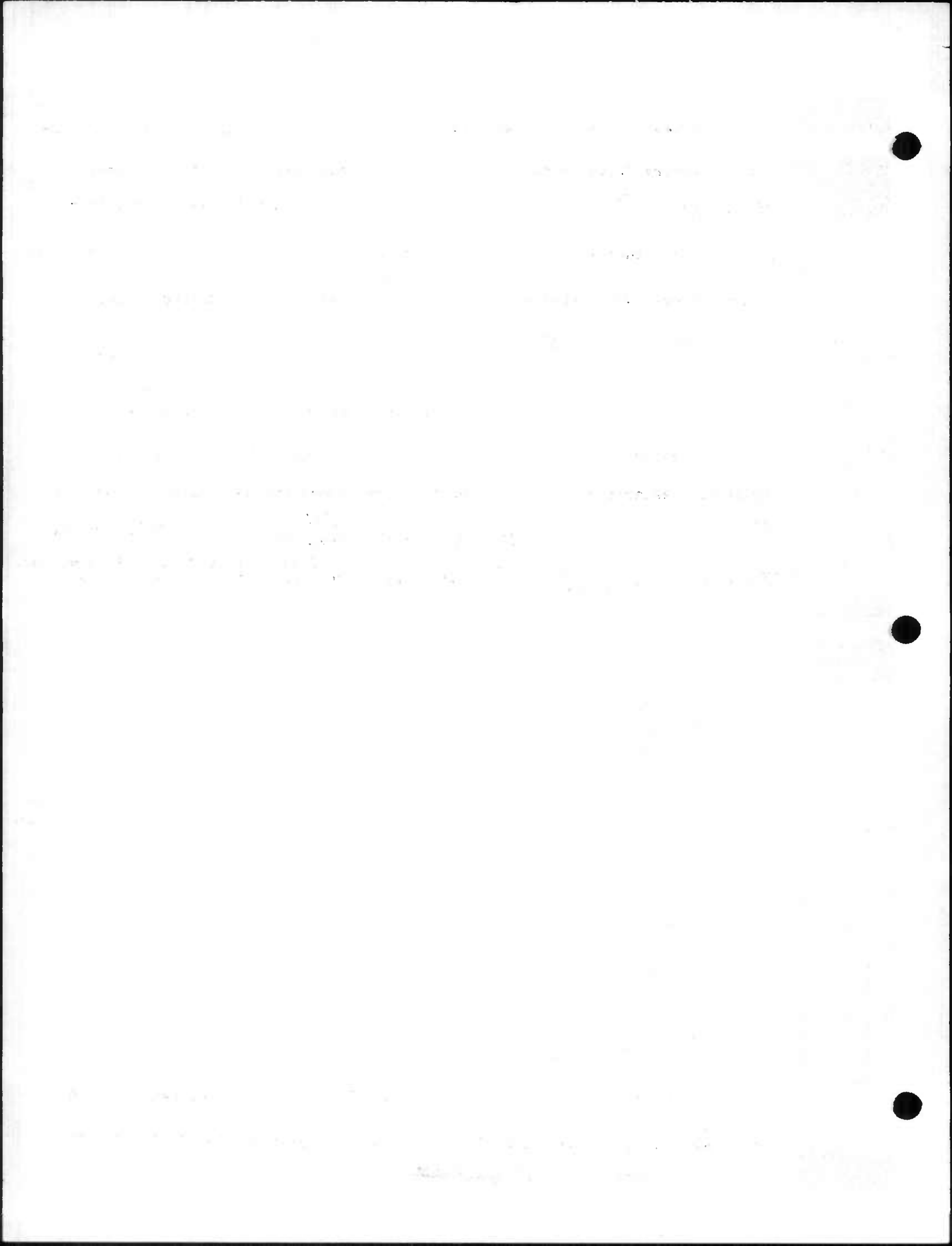
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34553

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Addie A Williams | | | | | | 2. Date of Death
Month November Day 3 Year 1996 | | 3. Time of Death
8:10AM | |
| | 4a. Facility Name (If not institution, give street and number)
Annapolis Nursing & Rehabilitation Center | | | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
579-24-2076 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
94 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 26 1901 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Davidsonville | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
3517 Jamestown Road | | | | 10f. Zip Code
21035 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | | 18b. Kind of Business/Industry
Home | |
| | 17. Father's Name (First, Middle, Last)
Milton Whaling | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Stella Sullivan | | | |
| To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print)
Nellie E. Ela-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3517 Jamestown Road Davidsonville, Maryland 21035 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 11/6/96 | | Data
Brentwood, Maryland | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Failure to thrive
Due to (or as a consequence of):
b. Fractured hip
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D05192 | | 29d. Date signed (Month, Day, Year)
November 5, 1996 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard I. Hochman, M.D. 1833 Forest Drive Annapolis, Maryland 21401 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
NOV 07 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34554

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CALVIN L. WALLACE

2. Date of Death

Month Day Year
OCT. 31 1996

3. Time of Death

0745

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

220-84-1199

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

31 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
DEC. 2 1964

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND10b. County
ANNE ARUNDEL10c. City, Town or Location
ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

411 WASHINGTON STREET

10f. Zip Code

21403

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12thCollege (1-4 or 5+)
2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HAIR STYLIST

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

ROBERT WALLACE

18. Mother's Name (First, Middle, Maiden Surname)

BRENDA OFFER

19a. Informant's Name/Relationship (Type, Print)

BRENDA ABNEY (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

411 WASHINGTON ST. ANNAPOLIS, MD. 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILL CREST CEMETERY

Date

11/5/96

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Harry J. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metabolic Acidosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Today

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

Today

c. Recurrent pneumonia

Due to (or as a consequence of):

3 months

d. Human Immunodeficiency virus Infection 3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Charles

29c. License number

D08314

29d. Date signed (Month, Day, Year)

10/31/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George C. Samaras MD 205 Ridgely Ave Annapolis MD 21403

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34555

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS LUCILLE ASHLEY

2. Date of Death

Month Day Year
NOVEMBER 8, 1996

3. Time of Death

0255

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Deaton Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

5. Social Security Number

216-30-7157

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 12 1933

9. Birthplace (State or Foreign Country)

Balto. Md.

Usual Residence of Decedent

10e. State

Md.

10b. County

City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1203 Cleveland Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
218e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker/Housewife

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

Charles Henry Hashagen

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Virginia Jacobs

19a. Informant's Name/Relationship (Type, Print)

Ronald T. Ashley/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1203 Cleveland Street Baltimore, Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Nov 11
1996

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Eugene J. Costello

22. Name and Address of Facility

McCully Funeral Home of Brooklyn
237 Patapsco Ave. Baltimore, md 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. End stage renal disease

Due to (or as a consequence of):

b. Diabetes mellitus

Due to (or as a consequence of):

c. HPN

Due to (or as a consequence of):

d. Peripheral arterial disease

Approximate
Interval Between
Onset and Death

Not Known

"

"

"

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicida 4 ☐ Homicida28a. Date of Injury
(Month, Day, Year)28b. Time of
injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Mohdhan

29c. License number

D34974

29d. Date signed (Month, Day, Year)

11. 8-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5865 Robert oliver pl. #121, Columbia, MD 21045

State
Registrar

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

L. Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34556

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Anderson

2. Date of Death

November 15 1996 00:01

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

213-30-4398

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 18, 1932 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3302 Ramona Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Navar Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

6th grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Orderly

16b. Kind of Business/Industry

University Hospital

17. Father's Name (First, Middle, Last)

Henry S. Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Pearl H. Herman

19a. Informant's Name/Relationship (Type, Print)

Sandra R. Brosious (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 W. Washington Avenue, Magnolia New Jersey 08049

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park Cem. 11-20 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert J. Godard, Jr.

22. Name and Address of Facility

Schimunek Funeral Home
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Alcoholic Liver Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Several Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Meim M.D.

29c. License number

P09755

29d. Date signed (Month, Day, Year)

November 15 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Alexander Reiss M.D. 22 S. Greene St Baltimore MD 21201

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia Jackson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

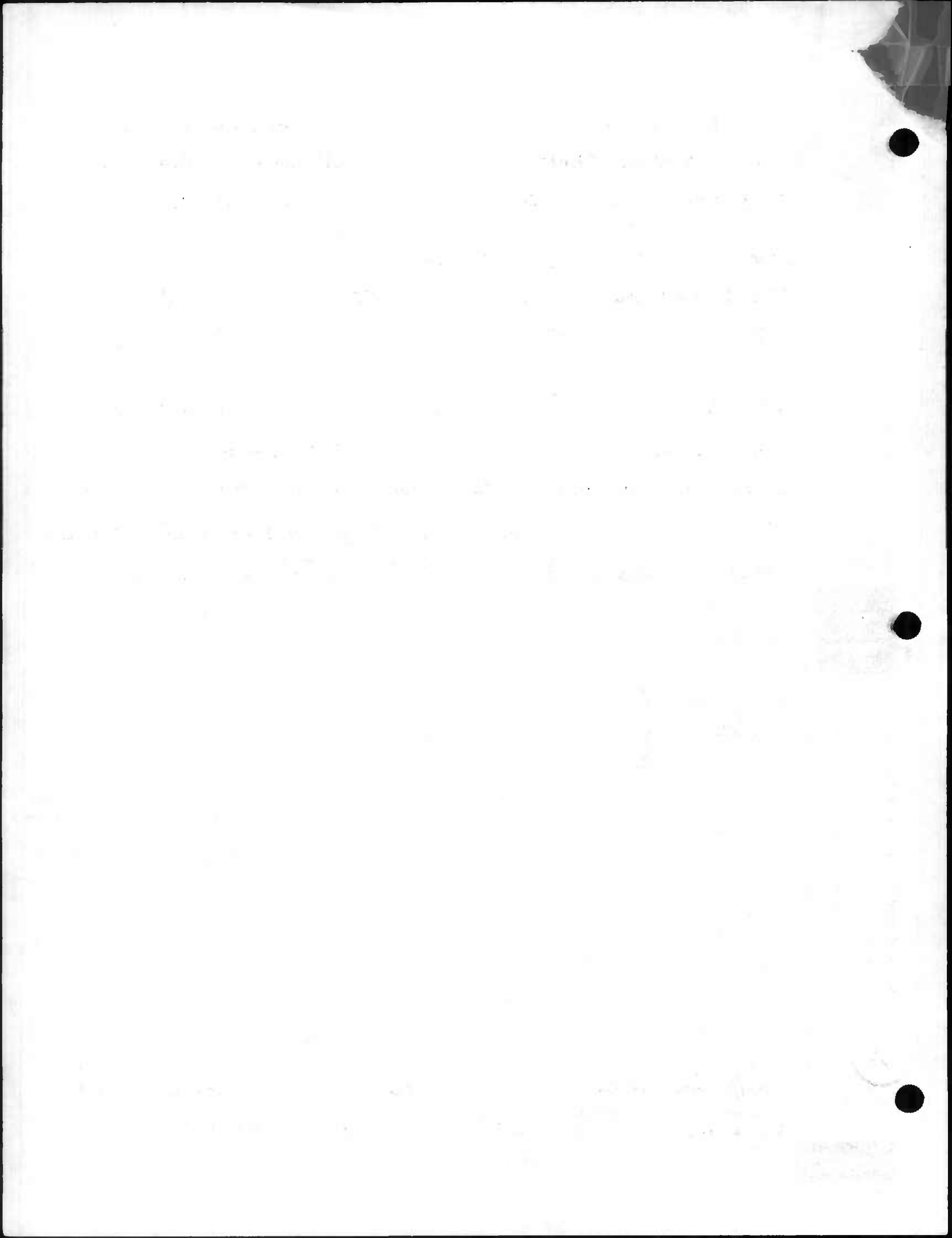
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34557

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Arnold

2. Date of Death

November 13th 1996

3. Time of Death

9:50 pm

4a. Facility Name (If not institution, give street and number)

Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

251-10-2091-A

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10/26/1916

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Locallon

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2802 Ulman Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 02/1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Sacondary (0-12)

College (1-4 or 5+)

Grade school

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

General Refractories

17. Father's Name (First, Middle, Last)

John Arnold

18. Mother's Name (First, Middle, Maiden Surname)

Ola Blossingame

19a. Informant's Name/Relationship (Type, Print)

Clifton Singleton

nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2802 Ulman Avenue Baltimore, Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville

Date

11/22/96

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee

Herbert E. Hutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bacterial Pneumonia

Due to (or as a consequence of):

18 days

c. Metastatic Prostate Cancer

Due to (or as a consequence of):

3 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

96012

29d. Date signed (Month, Day, Year)

Nov 14th 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frencil Johns Hopkins Bayview Medical Center

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

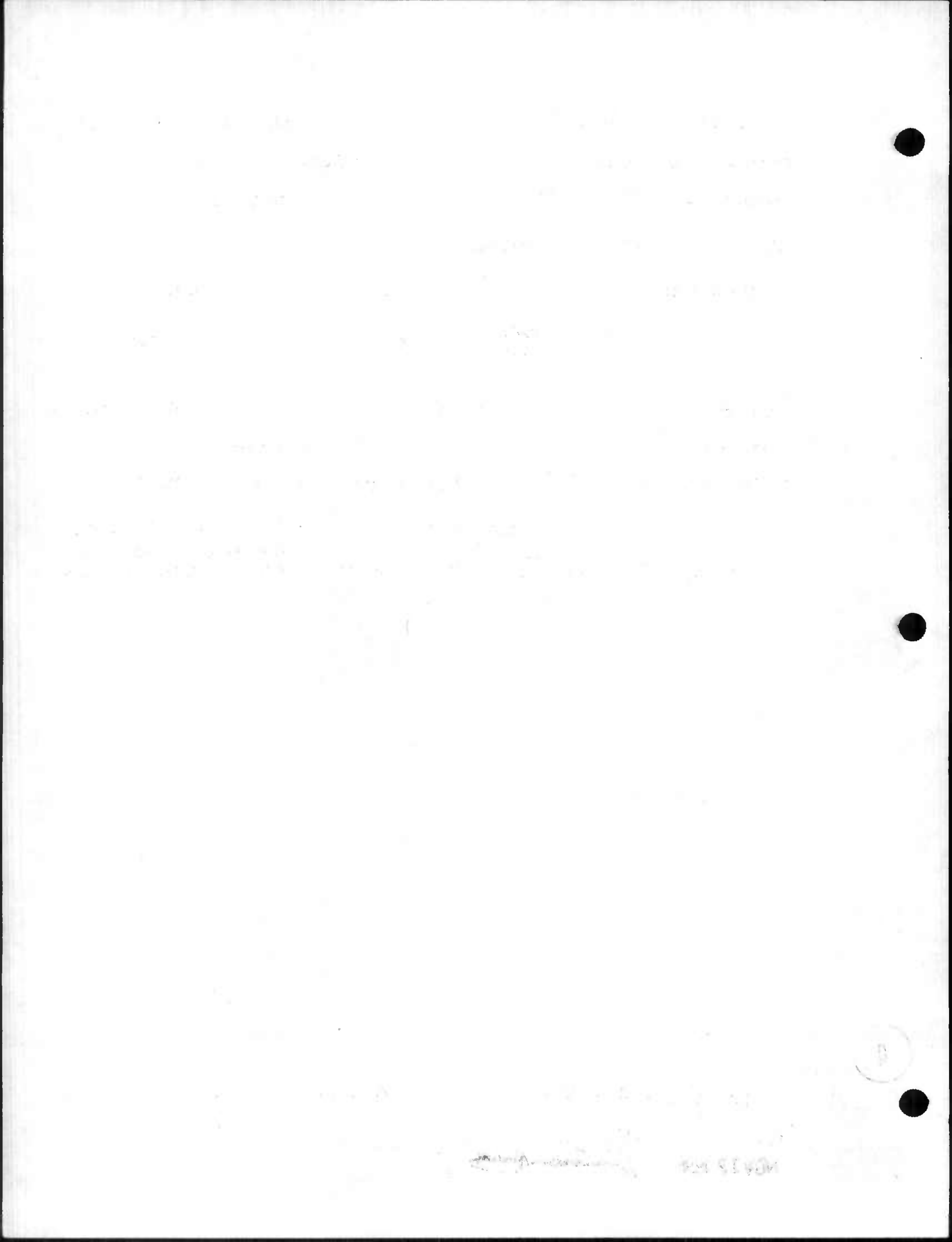
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34558

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Thomas Ambrose Jr.

2. Date of Death

November 14, 1996 3:00pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1328 Sulphur Spring Road

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

5. Social Security Number

214-14-3977

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30, 1915

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State
Maryland10b. County
Baltimore10c. City, Town or Location
Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1328 Sulphur Spring Road

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1941
194513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mortician

16b. Kind of Business/Industry

Funeral Service

17. Father's Name (First, Middle, Last)

Joseph T. Ambrose Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Stella Mae Ayres

19a. Informant's Name/Relationship (Type, Print)

Alice A. Ambrose, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1328 Sulphur Spring Road Arbutus, MD 21227

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Memorial 11/18/96 Dorsey, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc. Arbutus
1328 Sulphur Spring Road 21227a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Ventricular Fibrillation
ASCD1 hr
30 1/2Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

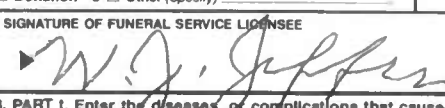
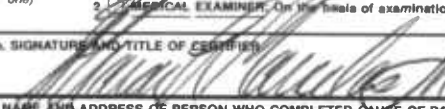
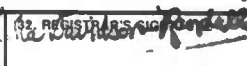
Medical Certification: To Be Completed by Physician/Medical Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
The Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 34559

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
HELEN BAILEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Nov. 08 1996 | | 3. TIME OF DEATH
7:33 A M | |
| 4. SOCIAL SECURITY NUMBER
230-46-9748 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
MAY 01, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Clinton | | 9c. COUNTY OF DEATH
Prince Georges | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Clinton | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
6811 Groveton Dr. | | | |
| 10f. ZIP CODE
20735 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 9 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Domestic | | 16b. KIND OF BUSINESS/INDUSTRY
Private Industry | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Will Hunt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mattie Hunt | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert Bailey, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6811 Groveton Dr., Clinton, Md., 20735 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Glenwood Cemetery 11/13/96 | | 20c. LOCATION — City or Town, State
Washington, D.C. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Frazier Funeral Home
389 Rhode Island Av., N.W., Washington, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive Intracerebral Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
b. Cerebrovascular Disease, Prior Stroke
DUE TO (OR AS A CONSEQUENCE OF):
c. Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
96 hrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D22026 | | 29d. DATE SIGNED (Month, Day, Year)
11/19/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S.L. Marselas, MD, 9440 Pennsylvania Ave., Upper Marlboro, Md., 20772 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 19 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34560

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CATHY BURKE

2. Date of Death

Month
NOV

Day

Year

9:29 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

578-78-9745

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 25 1960

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

--

10b. County

--

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

825 11th St., N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Navar Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John E. Burke

18. Mother's Name (First, Middle, Maiden Surname)

Virgie Cuffey

19a. Informant's Name/Relationship (Type, Print)

Virgie Burke Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

825 11th St., NE Wash., DC 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEM. 11-9-96

Date

20c. Location - City or Town, State

BRENTWOOD, MD.

21. Signature of Funeral Service Licensee

Sharon Johnson-Jalley

22. Name and Address of Facility

Capitol Mortuary
1425 Maryland Ave., NE Wash., DC 20002

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Status epilepticus

Due to (or as a consequence of):

b. Encephalopathy

Due to (or as a consequence of):

c. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

19 Days

Several months

Several years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Karim MD

29c. License number

D-18895

29d. Date signed (Month, Day, Year)

November 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MARYLAND

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34561

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Augustus

Brown Sr.

2. Date of Death

Month Day Year

11 12 96

3. Time of Death

11:35pm

4a. Facility Name (If not Institution, give street and number)

1710 W. Presstman Street

4b. City, Town, or Location of Death

21217

4c. County of Death

NA

Funeral
Director

5. Social Security Number

717-07-7886

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

8. Date of Birth

Month Day Year

05-15-13

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1710 W. PRESSTMAN STREET

10f. Zip Code

21217

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk.

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

HOUSING AUTH

17. Father's Name (First, Middle, Last)

DANIEL GASSAWAY

18. Mother's Name (First, Middle, Maiden Surname)

ELLA BROWN

19a. Informant's Name/Relationship (Type, Print)

ELLEN BROWN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1710 W. PRESSTMAN ST., BALTIMORE, MD # 17

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK 11-18 RANDALLSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janessa Love

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. metastatic Gastric Cancer

Due to (or as a consequence of):

b. malnourished

Due to (or as a consequence of):

c. cardiopulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Terance L. Lamb M.D.

29c. License number

D37203

29d. Date signed (Month, Day, Year)

November 15th 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Terance L. Lamb M.D.

4820 Seton Drive, Baltimore Md.

31. Date filed (Month, Day, Year)

NOV 19 1996

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital/Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34562

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Charles Theodore Bowman | | | | 2. Date of Death
Month Nov. Day 17 Year 1996 | | 3. Time of Death
9:30 pm. | |
| | 4a. Facility Name (If not institution, give street and number)
3220 Main Street | | | | 4b. City, Town, or Location of Death
Manchester | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
216-22-9768 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 24, 1922 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10e. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Manchester | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3220 Main Street | | 10f. Zip Code
21102 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Building Supervisor | | 16b. Kind of Business/Industry
Board of Education | | | |
| | 17. Father's Name (First, Middle, Last)
Harry Clayton Bowman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Catherine Shipley | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Treva M. Bowman - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3220 Main St. Manchester, Md. 21102 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wesley U.M. Church Cem. | | 20c. Location - City or Town, State
11-20-96 Hampstead, Md. | | | |
| | 21. Signature of Funeral Service Licensee
J. Eckhardt | | 22. Name and Address of Facility
Eckhardt Funeral Chapel
3296 Charmil Dr. Manchester, Md. 21102 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. pancreatic carcinoma
Due to (or as a consequence of):
b. with metastasis to liver
Due to (or as a consequence of):
c. peritoneal area
Due to (or as a consequence of):
d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
W.H. Foard M.D. | | 29c. License number
DO 2386 | | 29d. Date signed (Month, Day, Year)
11/18/96 | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
W.H. Foard M.D. 3223 MAIN ST. MANCHESTER, MD 21102 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
Julia Davidson-Randall | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34563

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janie Belle

2. Date of Death

Month Day Year
November 17 1996

3. Time of Death

10:09 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

249-32-9323

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 13, 1917

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1650 Ashburton Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

Dry Cleaners Operator

17. Father's Name (First, Middle, Last)

Benjamin Henson

18. Mother's Name (First, Middle, Maiden Surname)

Louise Brooks

19e. Informant's Name/Relationship (Type, Print)

Evelyn M. Moore

daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3412 Redman Road Baltimore, Maryland 21207

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD Nat'l Memorial Park

Date

Nov 22

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Dr. R. Terry

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls Parkway
Baltimore, Maryland 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e.

Metastatic Endometrial Cancer

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

one year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Small Bowel Obstruction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28e. Date of Injury
(Month, Day, Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matthew Esposito, MD

29c. License number

PD8643

29d. Date signed (Month, Day, Year)

November 17, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Matthew Esposito, MD 22 South Greene Street, UMMS, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia Swindler-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NOV 18 1965
J. Edgar Hoover

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34564

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN BREVARD | | | | 2. Date of Death
Month Nov Day 12 Year 1996 | | 3. Time of Death
10:45 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
221-64-8599 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
31 Yrs. | If Under 1 Year
Months 0 Days 0 | If Under 24 Hrs.
Hours 0 Min. 0 | 8. Date of Birth (Month, Day, Year)
October 21, 1965 | | 9. Birthplace (State or Foreign Country)
Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
5627 Columbia Road | | | | 10f. Zip Code
21044 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Divisional Manager | | 16b. Kind of Business/Industry
Ethicon Endo-Surgery Johnson & Johnson | | |
| 17. Father's Name (First, Middle, Last)
Robert Brevard | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Joan C. Leggins | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joan C. Leggins (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1300 South Farnview Drive Dover, Delaware 19904 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethany Baptist Church Cemetery | | 20c. Location - City or Town, State
Lynchburg, Virginia | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc
5555 Twin Knolls Road Columbia, Maryland 21045 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ACQUIRED IMMUNE DEFICIENCY SYNDROME yrs. | | | | | | | | Approximate Interval Between Onset and Death |
| Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
D25643 | | 29d. Date signed (Month, Day, Year)
November 12, 1996 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
2300 Dulaney Valley Rd Baltimore 21204 / KR Faulkner M | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

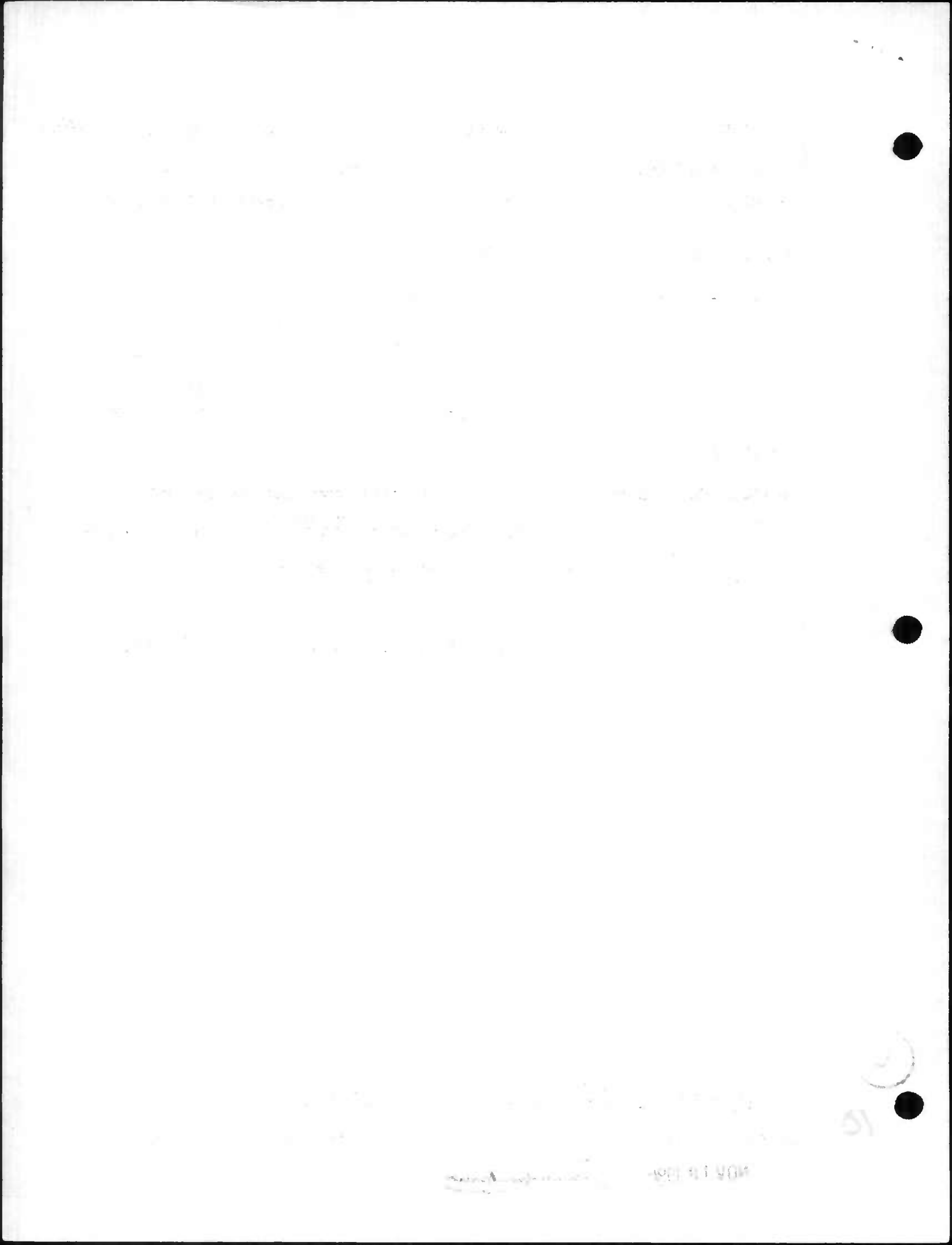
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34565

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emma S. BUTLER

2. Date of Death

November 17, 1996

3. Time of Death

6:45 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

402-68-3917

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 22, 1911

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Clarksville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11920 Meadow Vista Way

10f. Zip Code

21029

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

William Frank Stewart

18. Mother's Name (First, Middle, Maiden Summa)

Anna Thomas

19a. Informant's Name/Relationship (Type, Print)

John R. Butler, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11920 Meadow Vista Way Clarksville, Maryland 21029

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cove Haven Cemetery

Date

November 23 1996

20c. Location - City or Town, State

Lexington, Kentucky

21. Signature of Funeral Service Licensee

Nanda L. Lemmer

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

5555 Twin Knolls Road Columbia, Maryland 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

STROKE

Approximate Interval Between Onset and Death

2 days

e. Due to (or as a consequence of):

HYPERTENSION

years

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non-Insulin Dependant Diabetes Mellitus

glaucoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

N/A

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28d. Describe how injury occurred

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. B. Vellanki

29c. License number

D. 30469

29d. Date signed (Month, Day, Year)

November 17, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NANDAKUMAR B. VELLANKI, 5755 Cedar Ave

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

March 1938

MOA 18 1838

55

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34566

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaretta L. Babb

2. Date of Death
Month Day Year

Nov 16 96

3. Time of Death

9:05am

4a. Facility Name (If not institution, give street and number)

KESWICK

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-46-2476

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

04-19-1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTO.

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 DULANEY VALLEY RD.

10f. Zip Code

21204.

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOMEMAKER

17. Father's Name (First, Middle, Last)

OSCAR F. LACKEY

18. Mother's Name (First, Middle, Maiden Surname)

MARY MYER

19a. Informant's Name/Relationship (Type, Print)

LUCY B. WRIGHT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21619 GUNPOWDER RD. LINEBORO, MD. 21102.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

QUAKER CEMETERY

Date

11/23/96

20c. Location - City or Town, State

SPARKS, MD.

21. Signature of Funeral Service Licensee

William R. Jenkins

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic renal insufficiency

Approximate Interval Between Onset and Death

unknown

Due to (or as a consequence of):

b. Arteriosclerotic cardiovascular disease

unknown

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ruudal obstruction due to inflammation, status post gastrojejunostomy and feeding jejunostomy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Isabelle MacGregor MD.

29c. License number

D13657

29d. Date signed (Month, Day, Year)

November 16, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MABELLE MAE GREGOR KESWICK, TOW 40th ST BALTIMORE, MD 21211

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John R. Jenkins

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34567

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM R. CHAMBERS, JR.

2. Date of Death

Month Day Year
NOV. 12 1996

3. Time of Death

7:13 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

north arundel hospital

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

212-52-3176

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Oct. 20, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

914 Dogwood Road

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☐ No
If Yes, Give Year or Dates: 1968
1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
+ 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FireFighter

16b. Kind of Business/Industry

A.A.Co. Orchard Beach

17. Father's Name (First, Middle, Last)

William R. Chambers, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Phylis Murphy

19a. Informant's Name/Relationship (Type, Print)

Sandy L. Chambers Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

914 Dogwood Road Glen Burnie, Maryland 21060

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery Nov. 16, 1996

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► [Signature] M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

NOVEMBER 13, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARGARET A. KOREN 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34568

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carroll COOPER | | | | 2. Date of Death
Month November Day 17 Year 1996 | | 3. Time of Death
11:45 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rossville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
216-20-0727 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 5 1926 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Millersville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 11. Street and Number
505 Kenora Drive | | 11b. Zip Code
21108 | |
| | 11c. Citizen of What Country?
USA | | | | 12. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 13. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII | |
| To Be Completed by Physician/Medical Examiner | 14. Race - American Indian, Black, White, etc.
white | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
inspector | |
| | 16b. Kind of Business/Industry
WestingHouse | | | | 17. Father's Name (First, Middle, Last)
Charles N. Cooper | | 18. Mother's Name (First, Middle, Maiden Surname)
Ida Cooper | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Juanita Cooper Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
505 Kenora Drive Millersville Md. 21108 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | 20c. Location - City or Town, State
Baltimore Md. | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<i>Edward Lewis</i> | | | | 22. Name and Address of Facility
McCully Funeral Home of Pasadena
3204 Mountain Rd. Pasadena Md. 21122 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dua to (or as a consequence of):

Dua to (or as a consequence of):

Dua to (or as a consequence of):

Dua to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
1 Day | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>Meleque (M. EMDA DUL HAQUE, M.D.)</i> | | | |
| | 29c. License number
RD 1907 | | | | 29d. Date signed (Month, Day, Year)
November 18, 1996 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Emdadul Haque M.D. 9000 Franklin Square Drive Baltimore, MD 21237 | | | | 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | |
| | 32. Registrar's Signature
<i>Juanita Cooper</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

12/12/96, 1t Per med Ex
Item 23a, Part II, 27, 28a, b, c, d, e, f, Film 742, 12

State of Maryland / Department of Health and Mental Hygiene

96 34569

Certificate of Death

Reg. No.

M

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
CHARLES F. CAVEY, JR. | | 2. Date of Death
Month NOV. Day 12 Year 1996 | | 3. Time of Death
2:05 PM | |
| 4a. Facility Name (If not institution, give street and number)
MARYLAND CORRECTIONAL CENTER | | 4b. City, Town, or Location of Death
HAGERSTOWN | | 4c. County of Death
WASHINGTON | |
| 5. Social Security Number
217-84-2855 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
22 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year) |
| 9. Birthplace (State or Foreign Country)
Maryland | | | | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10a. State
Maryland | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | | |
| 10e. Street and Number
3634 Paine Street | | 10f. Zip Code
21211 | | 10g. Citizen of What Country?
U.S.A | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cabinet Maker | | 16b. Kind of Business/Industry
Construction | |
| 17. Father's Name (First, Middle, Last)
Charles F. Cavey, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Deborah Wood | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Charles F. Cavey, Sr. (Father) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3634 Paine Street, Baltimore, Maryland 21211 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem Gardens | | 20c. Location - City or Town, State
11/18 Timonium, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Md. 21211 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Correctional | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
12/12/96 | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Unknown | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Maryland division of corrections | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hagerstown, Maryland | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
NOVEMBER 13, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARYJANE S. KOCOR 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | |

State
Registrar

Handwritten text at the bottom of the page, possibly a signature or date, which is mostly illegible due to fading.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34570

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Conniff

2. Date of Death

November 17, 1996 3:15 pm

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Gilchrest Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-14-5589

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3-13-1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

908 E. 37th ST.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Dwight Hott

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Summers

19e. Informant's Name/Relationship (Type, Print)

Frances H. Leibensperger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

908 E. 37th St., Baltimore, MD 21218

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

11-21

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

William R. Jenkins

22. Name and Address of Facility

Henry W. Jenkins & Sons
4905 York Rd., Baltimore, MD 21212

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Liver Failure

Due to (or as a consequence of):

b. metastatic Lung Cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

non-insulin dependent diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

NA

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. A. Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

November 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley, MD

6701 N. Charles Street, Balto. MD 21204

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

R. A. Rendell

State
Registrar

Baltimore, Maryland 21215-0020

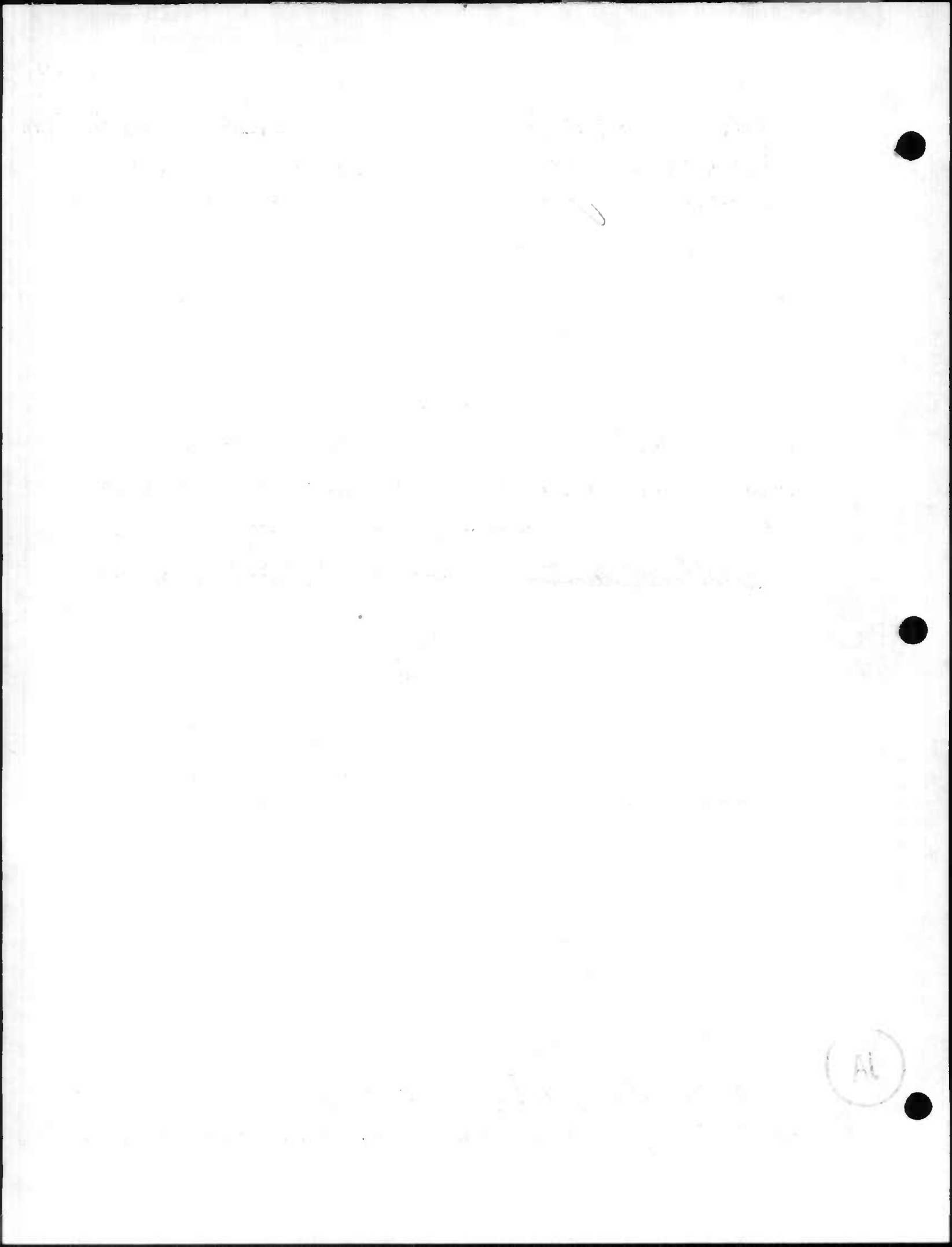
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34571

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WARD B. COE, JR

2. Date of Death

Month

Day

Year

NOVEMBER 12, 1996

3. Time of Death

5:25PM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-14-6840

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

08-24-1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1747 CIRCLE RD.

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ATTORNEY

16b. Kind of Business/Industry

LAWYER

17. Father's Name (First, Middle, Last)

WARD B. COE

18. Mother's Name (First, Middle, Maiden Surname)

MARGUERITE HALL

19a. Informant's Name/Relationship (Type, Print)

DIANA C. COE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1747 CIRCLE RD. TOWSON, MD. 21204.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LORRAINE PARK

Date

11/19/96

20c. Location - City or Town, State

BALTO., MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.

4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

e. RUPTURED THORACIC ANEURYSM

40 MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24121

29d. Date signed (Month, Day, Year)

11/12/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRUCE ROSENBERG, M.D. 515 FAIRMOUNT AVE., TOWSON, MARYLAND 21286

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

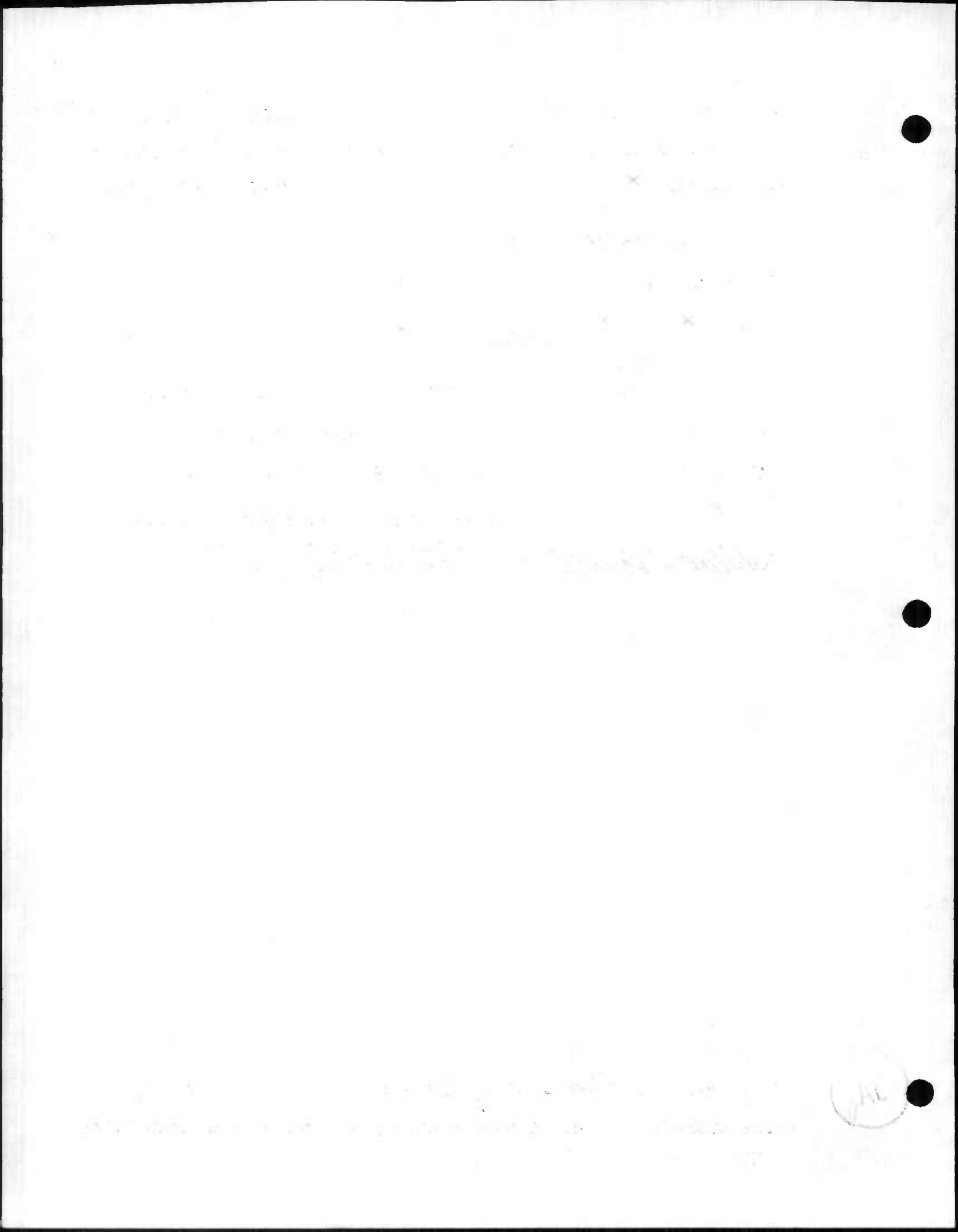
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

JA

State
Registrar



96 34572

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>George K Callahan</u> | | | | 2. DATE OF DEATH
MONTH <u>November</u> DAY <u>15</u> YEAR <u>1996</u> | | 3. TIME OF DEATH
<u>10:55am</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>577-40-2802</u> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>69</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>FEB 10, 1927</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>CHARLOTTE HALL VETERANS HOME</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>CHARLOTTE HALL</u> | | 9c. COUNTY OF DEATH
<u>ST. MARY'S</u> | |
| 10a. STATE
<u>MD.</u> | | 10b. COUNTY
<u>A.A. CO.</u> | | 10c. CITY, TOWN OR LOCATION
<u>SEVERNA PARK</u> | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<u>649 SALTZMAN ROAD</u> | | | | 10f. ZIP CODE
<u>21146</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES <u>WWII</u> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>WHITE</u> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u>
College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>PRINTER</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>PRINTING</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>ROY LEE CALLAHAN</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>FLORENCE FIFE</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>BRENDA CALLAHAN</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>649 SALTZMAN ROAD SEVERNA PARK MD 21146</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>MARYLAND VETERAN'S CEMETERY 11-18 CROWNSVILLE MD.</u> | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>HARDESTY FUNERAL HOME P.A. 12 RIDGELY AVE ANNAPOLIS MD. 21401</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CARDIAL ARREST</u>
DUE TO (OR AS A CONSEQUENCE OF):
a. <u>CHF</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>ASCD</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. <u>COPD</u>
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>MIOLVA</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>[Signature] P. PATEL MD</u> | | | | 29c. LICENSE NUMBER
<u>D 50249</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>11/16/96</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>PRANAY PATEL, 110 HUSP RD, #303, PR. FREDERICK MD 20678</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>11/15/96</u> | | 32. REGISTRAR'S SIGNATURE
<u>[Signature]</u> NOV 18 1996 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34573

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Marie Clement

2. Date of Death

Month
Nov.Day
14Year
1996

3. Time of Death

3:50PM

4a. Facility Name (If not institution, give street and number)

10705 Graeoch Road

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

434-12-5982

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Apr. 15, 1922

9. Birthplace (State or Foreign Country)

LA

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10705 Graeoch Road

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
None16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alfred Bienvenu

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Harris

19a. Informant's Name/Relationship (Type, Print)

Dianne Good (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4918 Worthington Way, Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

Nov. 18, 1996

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Shanda L Lemmer

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Rd. Columbia, MD 2104523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Aspiration Pneumonia

Due to (or as a consequence of):

c. Rectal Adenocarcinoma - recurrent -

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

2 weeks

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Anemia, Anorexia - Cachexia Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jon Munford

29c. License number

D 30573

29d. Date signed (Month, Day, Year)

11-15-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon Munford, M.D. 11065 Little Patuxent Parkway, Columbia MD 21044

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

of the hospital or attending physician: The law requires that the death certificate be executed
within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

RECEIVED

NOV 19 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34574
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--------------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE CONNOR | | | | 2. Date of Death
Month November Day 15 Year 1996 | | 3. Time of Death
4:42 A.M. | |
| | 4a. Facility Name (If not Institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-38-2060 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
55 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
6-18-1941 | | 9. Birthplace (State or Foreign Country)
Virginia |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
3771 Bruce Rd Apt J | | | 10f. Zip Code
21233 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Transit Driver | | 16b. Kind of Business/Industry
Mass Transit | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Salvina Connor | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Fannie Waller | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Rev John R Scott | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1005 Sayward Ave Baltimore MD 21234 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
London Park Cem | | Date
11/21/96 | | 20c. Location - City or Town, State
Balto. MD | |
| | 21. Signature of Funeral Service Licensee
Vaughn C Greene | | 22. Name and Address of Facility
5151 Baltimore National Dike
Vaughn C Greene Funeral Services | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of):
b. ACQUIRED IMMUNE DEFICIENCY SYNDROME
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | Approximate interval Between Onset and Death
weeks
5 yrs. |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| State
Registrar | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Kendall R Faulkner | | | | 29c. License number
D25643 | | 29d. Date signed (Month, Day, Year)
11/15/96 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

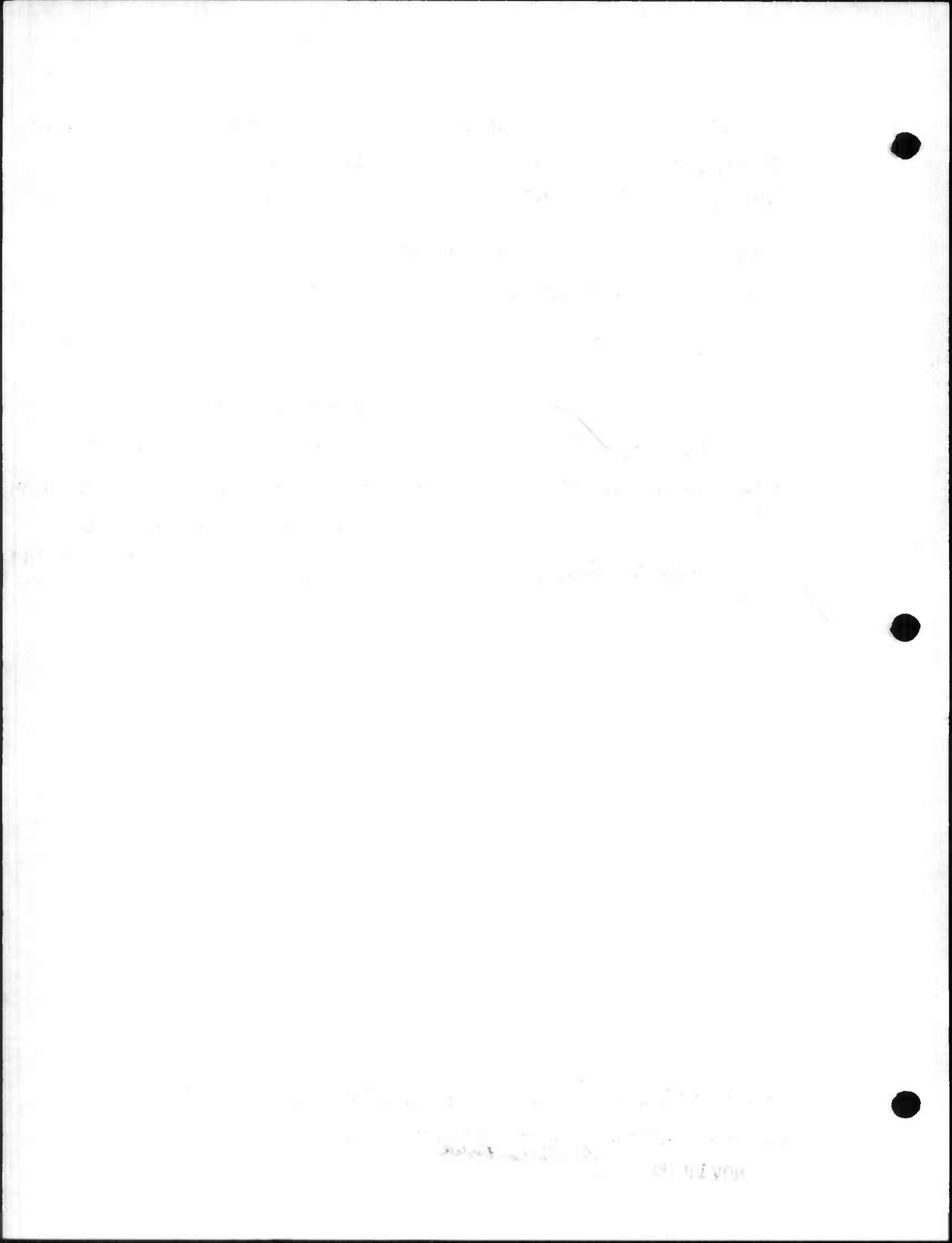
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34575

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jay V. Dixon

2. Date of Death

Month Day Year
Nov. 18, 1996

3. Time of Death

1:30 p.m.

4a. Facility Name (If not institution, give street and number)

Genesis Nursing Home

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

251-10-4681

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 8, 1915

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

405 Valley Meadow Circle

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Auto Mech.

16b. Kind of Business/Industry

J.B.A.

17. Father's Name (First, Middle, Last)

Mack Dixon

18. Mother's Name (First, Middle, Maiden Surname)

Emma Byers

19a. Informant's Name/Relationship (Type, Print)

Robert J. Dixon Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17 Phyllis Drive Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc. Nov. 19, 1996

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Thomas S. Polyrus

22. Name and Address of Facility

McCully Funeral Home

3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Metastatic Colon Cancer*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Several months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD Dehany MD

29c. License number

D-40521

29d. Date signed (Month, Day, Year)

November 19, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR MAKESH OCHANEY

1845 Oakwood Road Suite 205
Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

R Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34576

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Joseph Duffy

2. Date of Death

November 16 1996

3. Time of Death

6:30 pm

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

212-48-9936

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 5, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Carney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9730 Britnay Lane

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1968-1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Auto Repair

17. Father's Name (First, Middle, Last)

Francis Duffy

18. Mother's Name (First, Middle, Maiden Surname)

Marie Calp

19a. Informant's Name/Relationship (Type, Print)

Mrs. Catherine M. Duffy/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9730 Britnay Lane Carney, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

11/20/96

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrhythmia

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Diabetes mellitus

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

minutes

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypoxic encephalopathy

Multiple strokes

Bilateral pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stacy Ross MD

29c. License number

D36924

29d. Date signed (Month, Day, Year)

11/16/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stacy Ross MD 3001 Hospital Drive Family Health Ctr Cheverly, Md 20785

31. Date filed (Month, Day, Year)

Nov 19 1996

32. Registrar's Signature

J. A. Davidson

State Registrar

Baltimore, Maryland 21215-0020

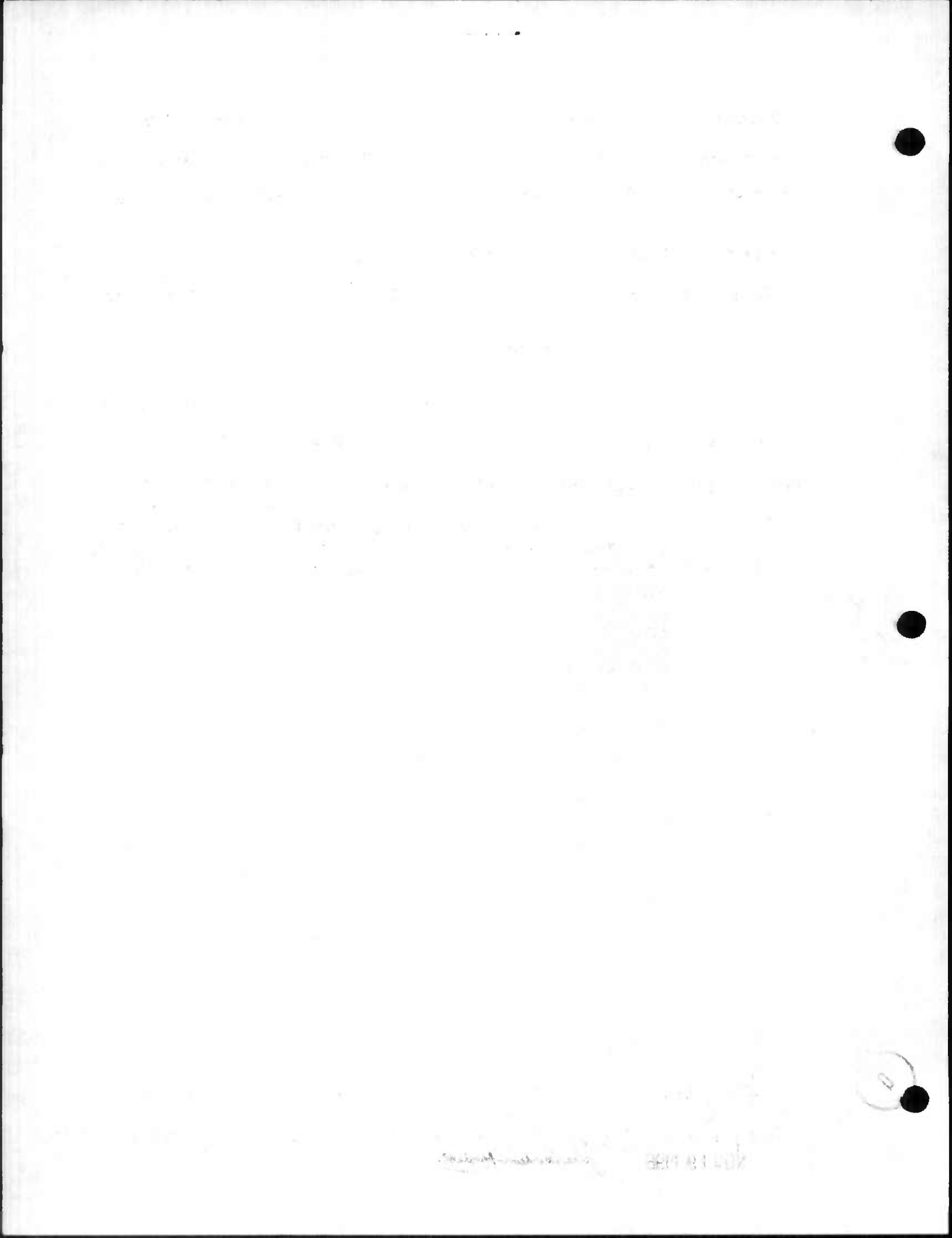
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760. The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34577

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Dubey

2. Date of Death

November 16 1996

3. Time of Death

03:28

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

049-09-3138

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 25, 1910

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1310 Charmuth Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Luke M. Madden

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Smith

19a. Informant's Name/Relationship (Type, Print)

Mr. Philip J. Dubey (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1310 Charmuth Road Lutherville, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sacred Heart Cemetery 11/22/96

Date

20c. Location - City or Town, State

Meriden Connecticut

21. Signature of Funeral Service Licensee

Michael Duck

22. Name and Address of Facility

Towson, Maryland
Ruck Towson Funeral Home, Inc. 1050 York Road23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Renal Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

4 months

c. Colonic Perforation

Due to (or as a consequence of):

4 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Myelofibrosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

M6335 RES-000

29d. Date signed (Month, Day, Year)

November 16, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

600 N. Wolfe St Baltimore, Greg M. Lucas MD

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Jana Vardan-Randall

State
Registrar

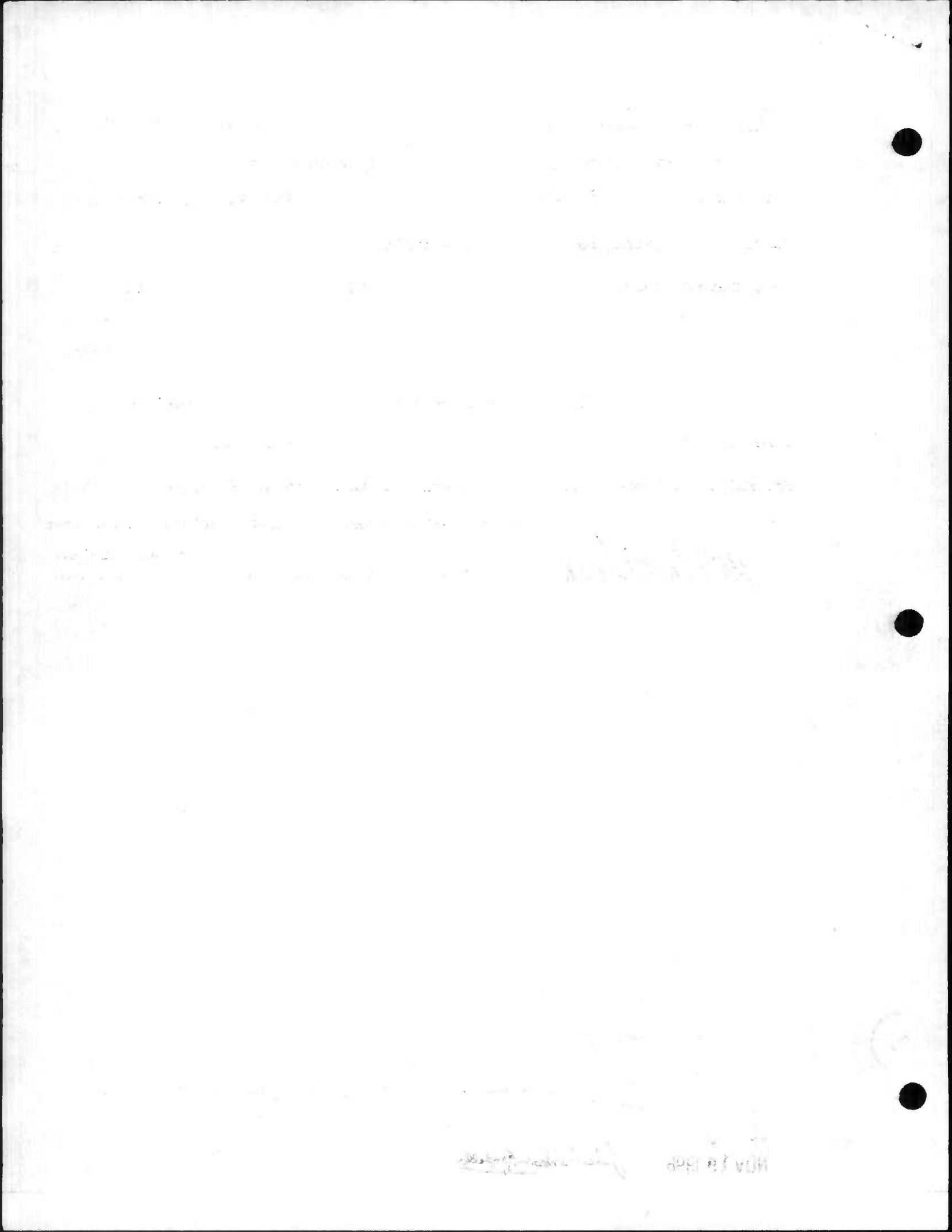
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34578

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanne Marie DiPasquale

2. Date of Death

November 9, 1996

3. Time of Death

12:38 A

4a. Facility Name (If not institution, give street and number)

6905 Dunmanway

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-32-4918

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 23, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6905 Dunmanway

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
G.E.D.

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Elvin Wright

18. Mother's Name (First, Middle, Maiden Surname)

Ora Schultheis

19e. Informant's Name/Relationship (Type, Print)

Guy W. Welty, Sr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3200 Hackberry Lane, York, PA 17404

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 11/12/96

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Artery Disease

Due to (or as a consequence of):

Diabetes Mellitus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1993

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

27907

29d. Date signed (Month, Day, Year)

11-14-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10755 FALLS RD #200

LUTHERVILLE

MD 21023

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

96 34579

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY EAGEN | | | | 2. DATE OF DEATH
MONTH November DAY 18 YEAR 96 | | 3. TIME OF DEATH
7:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER
212-16-9626 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
78 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
9, 18, 18 | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number)
MARCY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
City | |
| 10a. STATE
Md. | | 10b. COUNTY
City | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1213 Light St. Harbor Inn Conv.Home | | | | 10f. ZIP CODE
21230 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (13-16 or 17+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
typist | | 16b. KIND OF BUSINESS/INDUSTRY
Crown Cork & Seal | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John J. Eagen, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary C. Furlong | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jane F. Gerber God-daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
201 Oakdale Rd. Linthicum, Md. 21090 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
New Cathedral Cem. Nov 20 1996 | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
McCully Funeral Home of South Balto. 130 E. Fort Ave., Baltimore, Md. 21230 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CEREBRO-VASCULAR ACCIDENT
DUE TO (OR AS A CONSEQUENCE OF):
b. PARTIAL BOWEL RESECTION
DUE TO (OR AS A CONSEQUENCE OF):
c. OBILVIE'S Syndrome
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
24L
3 WKS
4 WKS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
AV 4764355 8573 | | 29d. DATE SIGNED (Month, Day, Year)
11/18/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DAVID SHAZ, UNIVERSITY OF MARYLAND MEDICAL SYSTEM, 22 S. GREENE ST, BALTIMORE MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 19 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

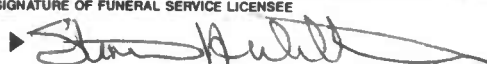
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 34580

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
VIRGINIA N. EISENHARDT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOV. 11, 1996 | | 3. TIME OF DEATH
10:45 A M | |
| 4. SOCIAL SECURITY NUMBER
220-24-6884 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
DEC. 1, 1908 | |
| 8. FACILITY NAME (If not institution, give street and number)
46 S. Schroeder Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
46 S. Schroeder Street | | | | 10f. ZIP CODE
21223 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Elmer A. Banks | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sophia Miller | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Albert R. Eisenhardt - son | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
46 S. Schroeder St., Baltimore, Md. 21223 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Meadowridge Memorial Park 11/15 | | 20c. LOCATION — City or Town, State
Elkridge, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Gary L. Kaufman Funeral Home of Elk., Inc.
5695 Main St., Elkridge, Md. 21227 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.


IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Coronary Artery Disease

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hyperkalemia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Anil Uberoi MD | | | | 29c. LICENSE NUMBER
D26748 | | 29d. DATE SIGNED (Month, Day, Year)
11/12/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ANIL UBEROI 4419 FALLS RD BALTO MD 21011 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 19 1996 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 34581

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Rita GADO | | | | 2. DATE OF DEATH
MONTH Nov. DAY 13 YEAR 1996 | | 3. TIME OF DEATH
5:50 AM | |
| 4. SOCIAL SECURITY NUMBER
213-20-5916 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct. 17 1914 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore Md. | |
| 9c. COUNTY OF DEATH
City | | | | 10a. STATE
MD. | | 10b. COUNTY
City | |
| 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
600 Light Street Apt. 911 | |
| 10f. ZIP CODE
21230 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife/Domestic | |
| 16b. KIND OF BUSINESS/INDUSTRY
Home Owner | | 17. FATHER'S NAME (First, Middle, Last)
Harry Hyser | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Rebstock | | 19a. INFORMANT'S NAME (Type/Print)
Julian Scarborough (Son) | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6537 Pampano Drive Glen Burnie Md. 21061 | | 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery Nov. 15 1996 | | 20c. LOCATION — City or Town, State
Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>David A. Hyser</i> | | 22. NAME AND ADDRESS OF FACILITY
McCully Funeral Home of South Balto.
130 E. Fort Ave. Baltimore Md. 21230 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → GI bleed.

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Lung CANCER.
b.
c.
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Haman M. Reschke</i> | |
| 29c. LICENSE NUMBER
P09753 | | 29d. DATE SIGNED (Month, Day, Year)
11/13/96 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
22 South Greene St. Baltimore MD 21228 | | 31. DATE FILED (Month, Day, Year)
NOV 19 1996 | |
| 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, the medical examiner must be notified at once.

2

Handwritten signature

JOHN DOE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34582

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY W. GOLDWEIS

2. Date of Death

November 16, 1996 5:05 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

City

5. Social Security Number

217-09-8296

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 18 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

645 Ellerslie Rd.

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Packer

16b. Kind of Business/Industry

Allied Chemical

17. Father's Name (First, Middle, Last)

George Wicklein

18. Mother's Name (First, Middle, Maiden Surname)

Stella Bailey

19a. Informant's Name/Relationship (Type, Print)

John N. Mullen Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1509 Race Street Baltimore, Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Park

Date

NOV. 21 1996

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

Harold A. Taylor

22. Name and Address of Facility

McCully Funeral Home of South Balto.
130 E. Fort Ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

PULMONARY EMBOLISM

Due to (or as a consequence of):

b.

MYO CARDIAL INFARCTION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 day

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASThma, Hypertension, diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Horodyski, MD.

29c. License number

AS2441616

29d. Date signed (Month, Day, Year)

November 16, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES HORODYSKI Harbor Hospital

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34583

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID GREEN

2. Date of Death

Nov. 13 1996

3. Time of Death

03:25 P.M.

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

229-16-8665

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 13, 1912

9. Birthplace (State or Foreign Country)

LIVELY, VA

Usual Residence of Decedent

10e. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1617 E. 32 nd street

10f. Zip Code

21218

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8 th

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

LOCH RAVEN APT.

17. Father's Name (First, Middle, Last)

SOLOMAN GREEN

18. Mother's Name (First, Middle, Maiden Surname)

ELLA

19a. Informant's Name/Relationship (Type, Print)

WILLIE G. GREEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1617 E. 32 nd STREET, BALTIMORE, MD #18

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

VOSHALL MEMORIAL GARDENS 11-18 DUNDALK, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM. C. MARCHFH.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. pneumonia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

5 days

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wazarian M.D.

29c. License number

R8485

29d. Date signed (Month, Day, Year)

Nov. 13, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEANETTE NAZARIAN M.D. 22 S. GREENE ST. BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

NOV 19 1996

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

2

United States of America

Department of the Interior

Bureau of Land Management

Washington, D.C.

June 1, 1964

Dear Sir:

I am writing to you regarding the

land use planning for the

public lands in the

State of California.

The following information is

being provided to you for your

information and use.

Sincerely,
[Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34584

Per. Med. Ex.

Item 23a, Part 11, 27 Film 742, 12/12/96, 1t

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TONYA

GILBERT

2. Date of Death

Month Day Year

OCTOBER 24, 1996

3. Time of Death

03:30 AM

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

1 14

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 10, 1996

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

--

10b. County

--

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1201 E St., N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Sterling Gilbert

18. Mother's Name (First, Middle, Maiden Sumama)

Esther McLean

19a. Informant's Name/Relationship (Type, Print)

Esther Gilbert Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1201 E St., NE Wash., DC 20002

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Pk

Date

10-31-96

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Sharon Johnson-Salley

22. Name and Address of Facility

Capitol Mortuary

1425 Maryland Ave., NE Wash., DC 20002

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SUDDEN INFANT DEATH SYNDROME (SIDS)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary Ann A. Koran M.D.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

OCTOBER 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Ann A. Koran M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

J. C. Randall-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34585

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|-------------------------------------|--|--|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Olive Gegner | | | | 2. Date of Death
Month November Day 14 Year 1996 | | | | 3. Time of Death
9:05 p.m. | |
| | 4e. Facility Name (If not institution, give street and number)
Stella Maris Nursing Center | | | | 4b. City, Town, or Location of Death
Towson | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
220-30-5882 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
97 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth
(Month, Day, Year)
Oct. 12, 1899 | | 9. Birthplace (State or Foreign Country)
Baltimore, Md. | | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Lutherville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
2108 Forest Ridge Road | | 10f. Zip Code
21093 | | 10g. Citizen of What Country?
United States | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | |
| | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
Phillip Amrhein | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Christensen | | 19a. Informant's Name/Relationship (Type, Print)
Kenneth Gegner (Son) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2108 Forest Ridge Rd. Lutherville, Md. 21093 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | Date
11/18/96 | | 20c. Location - City or Town, State
Baltimore Maryland | | 21. Signature of Funeral Service Licensee
Milton J. Knight Jr | |
| | 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore, Md. 21214 | | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
days
days | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
E. Nakhuda MD | | 29c. License number
1715504 | | 29d. Date signed (Month, Day, Year)
11.15.96 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Towson, MD 21204 | |
| | 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
Eddie Nakhuda | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

100 100 100 100
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34586

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES V. GRASSO, SR. | | | | 2. Date of Death
Month Day Year
November 14, 1996 | | 3. Time of Death
8:25 AM | |
| | 4a. Facility Name (If not institution, give street and number)
4122 Beachwood Road | | | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
155-24-8251 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 24, 1920 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
New Jersey | | 10b. County
Gloucester | | 10c. City, Town or Location
Williamstown | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
Washington Avenue | | | |
| | 10f. Zip Code
08094 | | | | 10g. Citizen of What Country?
United States | | | |
| To Be Completed by
Physician/Medical Examiner | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 Years
College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Road Maintenance | | 16b. Kind of Business/Industry
Highway Maintenance | | | |
| To Be Completed by
Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Frank Grasso | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosa | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Catherine Grasso/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4122 Beachwood Road Dundalk, Maryland 21222 | | | |
| To Be Completed by
Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph Cemetery | | 20c. Date
11/18/1996 | | 20d. Location - City or Town, State
Swedesboro, NJ | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |
| To Be Completed by
Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

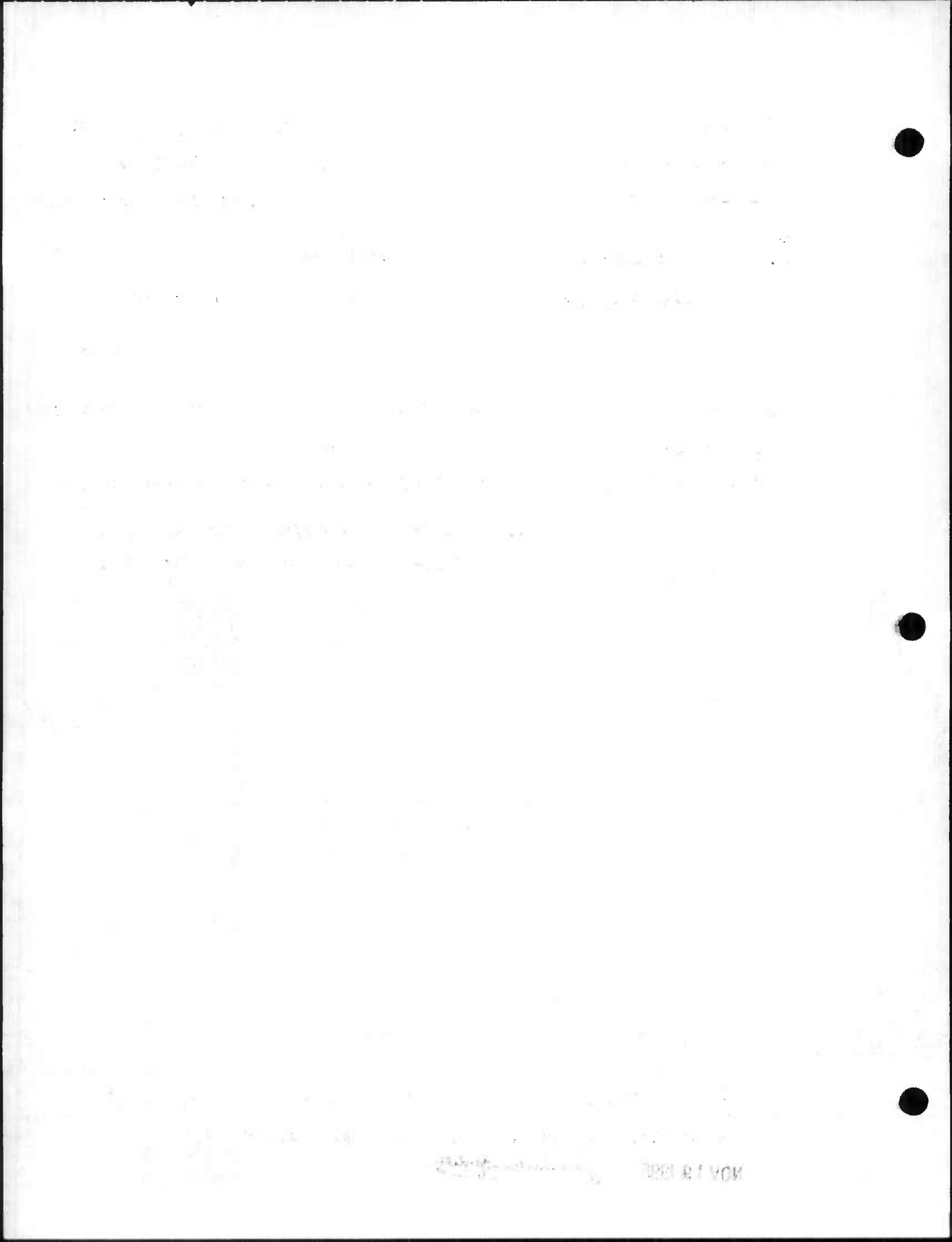
Immediate Cause (Final disease or condition resulting in death)
e. Coronary Artery Disease
Due to (or as a consequence of):
b. Ischemic Cardiomyopathy
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate interval Between Onset and Death
2 years
2 years | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by
Physician/Medical Examiner | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by
Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
050164 | | 29d. Date signed (Month, Day, Year)
11/14/96 | |
| To Be Completed by
Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Liji Mathew M.D. 9000 Franklin Square Drive Baltimore, MD 21237 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | 32. Registrar's Signature
 | | | |



| | | | | | | | |
|--|---|---|--|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH GIBSON | | 2. Date of Death
Month OCTOBER Day 21 Year 1996 | | 3. Time of Death
8:55AM | | |
| | 4e. Facility Name (If not Institution, give street and number)
1100 BOLTON STREET | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
103-34-4573 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
51 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 27, 1944 | 9. Birthplace (State or Foreign Country)
Unknown |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1100 Bolton Street | | 10f. Zip Code
21201 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
UNKNOWN
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates 1963-1969 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown College (1-4 or 5+) Unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Unknown | | 16b. Kind of Business/Industry
Unknown | | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Unknown | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Unknown | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Md. Veterans Cemetery | | Date
11/8/96 | 20c. Location - City or Town, State
Crownsville, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Stallings Funeral Home, P.A.
3111 Mountain Road, Pasadena, MD 21122 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed?
INSPECTION
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
NOVEMBER 11, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STEPHEN S. RADENTZ M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34588

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine F. Goode

2. Date of Death

Month November Day 17 Year 1996 5:20am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2716 Sparrows Pt. Rd.

4b. City, Town, or Location of Death

Edgemere

4c. County of Death

Baltimore

5. Social Security Number

220-18-3802

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 1, 1912

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2716 Sparrows Pt. Rd.

10f. Zip Code

21219

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Chamber Coleman

18. Mother's Name (First, Middle, Maiden Surname)

Sarah walker

19a. Informant's Name/Relationship (Type, Print)

Clara Kelly/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2716 Sparrows Pt. Rd. Balto., MD 21219

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National

Date

11/22

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Bladder

Approximate Interval Between Onset and Death

months

b. Heart block

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James A. Morton

29c. License number

015480

29d. Date signed (Month, Day, Year)

November 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. ZIMMING, MD Mercy Med. Center, BALT, MD 21202

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020. The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: This certificate has been signed by the attending physician and is to be completed by the funeral director. To the Funeral Director: After this certificate has been signed by the attending physician and is to be completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34589

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MILTON L. GREIF | | | | 2. Date of Death
Month Nov. Day 15 Year 1996 | | 3. Time of Death
8:45 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
NATIONAL LUTHERAN HOME | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY CO. | |
| Funeral
Director | 5. Social Security Number
216-16-9161 | | 6. Sex
2 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JUNE 8, 1921 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
BALTIMORE CITY | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
1439- RIVERSIDE AVENUE | | | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TIMEKEEPER-RECORDS CLERK-NOT AVAILABLE | | | | 16b. Kind of Business/Industry | |
| | 17. Father's Name (First, Middle, Last)
STANLEY M. GREIF | | | | 18. Mother's Name (First, Middle, Maiden Surname)
GERTRUDE L. THOMAS | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
REV.DR. REICHARD | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9701- VEIRS DR., ROCKVILLE, MD. 20850 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY-11/16-ALEXANDRIA, VA. | | Data | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
W. M. Hysong | | | | 22. Name and Address of Facility
HYSONG CO., INC.
1300- N ST., NW, WASH., DC 20005 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Adenocarcinoma of Lung
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
one year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pleural Mesothelioma | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 4 | 29b. Signature and title of certifier
Daniel H. Saller | | 29c. License number
D33138 | | 29d. Date signed (Month, Day, Year)
November 15, 1996 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel H. Saller MD 12850 Middlebrook Rd. Germantown MD | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
John Davidson | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital for Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34590

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUTHER

V.

GLACE

2. Date of Death

Month Day Year

NOVEMBER 15 1996

3. Time of Death

5:10 PM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-18-5730

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar. 8, 1923

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7838 Shepherd Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1943-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Electrical Contractors

17. Father's Name (First, Middle, Last)

Henry W. Glace

18. Mother's Name (First, Middle, Maiden Surname)

Edith Booker

19a. Informant's Name/Relationship (Type, Print)

Paul J. Glace (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

216 Welford Rd. Lutherville, Md. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

11/18/96

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Milton J. Knight Jr

22. Name and Address of Facility

Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CARCINOMA

Due to (or as a consequence of):

b. MULTIPLE MYELOMA

Due to (or as a consequence of):

c. DIFFUSE LARGE CELL LYMPHOMA

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Neeru Gupta, M.D.

29c. License number

P09302

29d. Date signed (Month, Day, Year)

NOVEMBER 15 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEERU GUPTA M.D. 5601 LOCK RAVEN BLVD BALT MD

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
1200 Broadway, New York, N.Y. 10018

1200 Broadway, New York, N.Y. 10018
1200 Broadway, New York, N.Y. 10018

1200 Broadway, New York, N.Y. 10018
1200 Broadway, New York, N.Y. 10018

1200 Broadway, New York, N.Y. 10018
1200 Broadway, New York, N.Y. 10018

1200 Broadway, New York, N.Y. 10018
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1200 Broadway, New York, N.Y. 10018
1200 Broadway, New York, N.Y. 10018

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34591

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rochelle B Gissentaner

2. Date of Death

November 16 1996

3. Time of Death

8:00 am

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

Funeral
Director

5. Social Security Number

229-11-8187

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

27

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 11, 1969

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4503 Pimlico Rd.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Library

17. Father's Name (First, Middle, Last)

Daniel Ward

18. Mother's Name (First, Middle, Maiden Surname)

Deborah Gissentaner

19a. Informant's Name/Relationship (Type, Print)

Mrs. Irene Yow

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4503 Pimlico Rd. Balto. Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

11/21/96

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. End Stage Renal Disease

Due to (or as a consequence of):

c. Acquired Immodeficiency Syndrome

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel A. Singer MD

29c. License number

P10208

29d. Date signed (Month, Day, Year)

11-16-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel A. Singer, MD, 22. S. Green St. Balto. MD 21201

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

G. J. Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34592

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Jane Guess

2. Date of Death
Month Day Year

November 15 1996

3. Time of Death

6:45 P.M.

4a. Facility Name (If not institution, give street and number)

5110 Ardmore Way

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-20-1199

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

June 27, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore, City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5110 Ardmore Way

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Bantz

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Murphy

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary J. Dietrich

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4409 Wynn Road Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

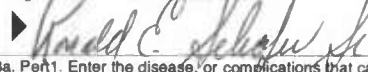
Date

11/18/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Metastatic Lung Cancer
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

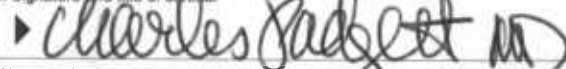
28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D15546

29d. Date signed (Month, Day, Year)

Nov. 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Padgett MD, 5601 Loch Raven Blvd., Baltimore, MD 21239

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

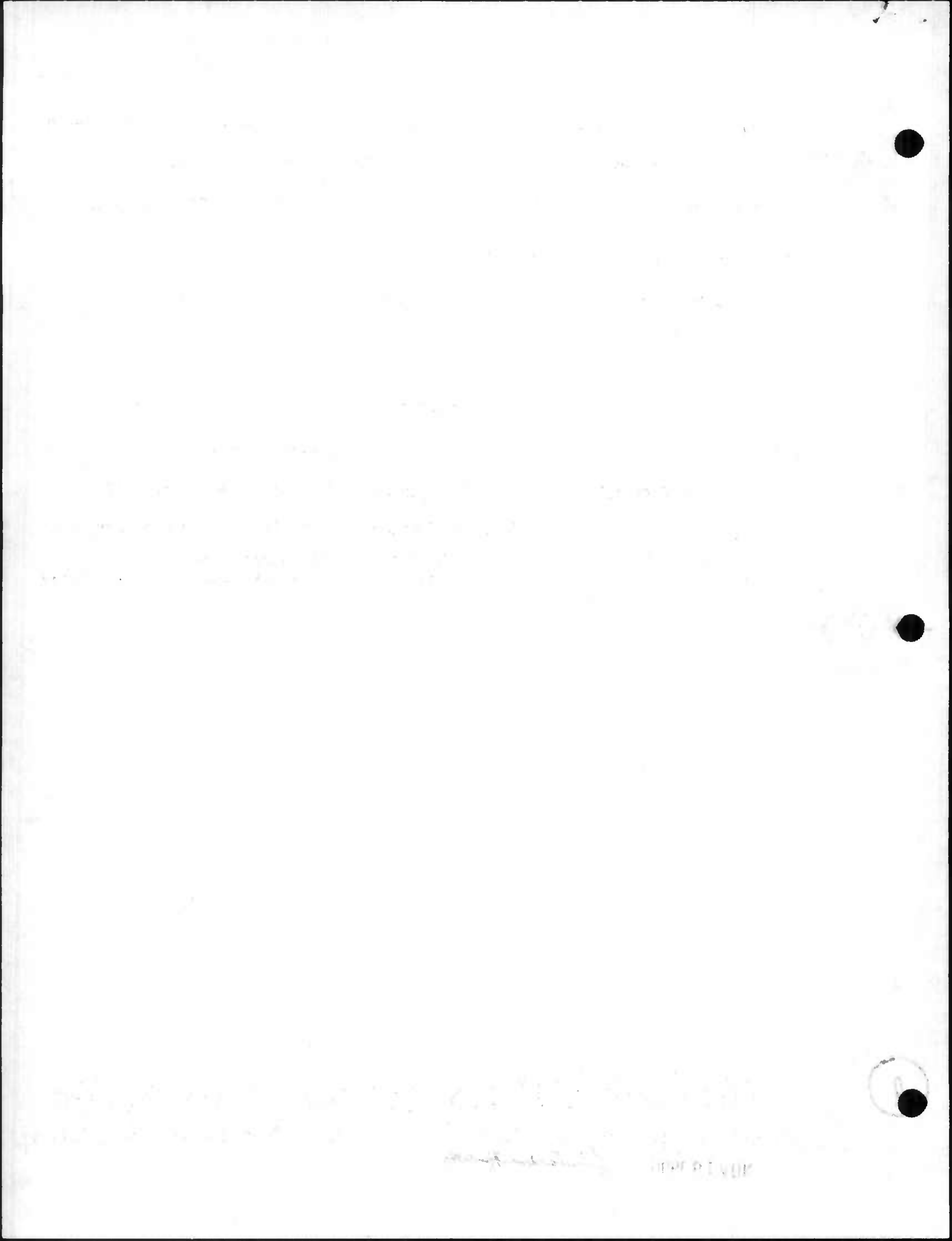
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



11/22/96 t.t

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>WILLIAM HOWELL</i> | | | | 2. Date of Death
Month Day Year
<i>NOVEMBER 17 1996</i> | | 3. Time of Death
<i>0855</i> | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>NORTHWEST HOSPITAL CENTER</i> | | | | 4b. City, Town, or Location of Death
<i>RANDOLPH</i> | | 4c. County of Death
<i>BALTIMORE</i> | | | | |
| Funeral
Director | 5. Social Security Number
<i>215-24-5098</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>72</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>1926</i>
<i>Mar 28, 1924</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
<i>Maryland</i> | | | 10b. County
<i>Baltimore</i> | | 10c. City, Town or Location
<i>Woodlawn</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
<i>2412 Poplar Drive</i> | | | | | 10f. Zip Code
<i>21207</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>WWII</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) | | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Underground Cable</i> | | | 16b. Kind of Business/Industry
<i>C & P Telephone Co.</i> | | | |
| 17. Father's Name (First, Middle, Last)
<i>Frank F. Houck</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Estelle Kramer</i> | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Mrs. Gloria E. Houck</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2412 Poplar Drive Baltimore, Maryland 21207</i> | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>MD Veterans Cemetery</i> | | | 20c. Location - City or Town, State
<i>11/21 Garrison, Maryland</i> | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Stephen M Jenkins</i> | | | | | 22. Name and Address of Facility
<i>Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD 21133</i> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Gastric Cancer with metastasis</i>
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>b. </i>
Dua to (or as a consequence of):
<i>c. </i>
Dua to (or as a consequence of):
<i>d. </i> | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Biggs MD</i> | | | | 29c. License number
<i>D44505</i> | | | |
| | | | | 29d. Date signed (Month, Day, Year)
<i>November 17, 1996</i> | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>A J IMPERIAL - Northwest Hosp. Center</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>Nov 19 1996</i> | | | | 32. Registrar's Signature
<i>Julia Burdon-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34594

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ADOLF

HOCHBERGER

2. Date of Death

Month Day Year
NOVEMBER 7, 1996

3. Time of Death

9:40 AM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

176-01-0441

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09/12/1905

9. Birthplace (State or Foreign Country)

HUNGARY

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES MANAGER

16b. Kind of Business/Industry

KANN'S DEPT. STORE

17. Father's Name (First, Middle, Last)

ISAAC HOCHBERGER

18. Mother's Name (First, Middle, Maiden Surname)

HANI KLEIN

19a. Informant's Name/Relationship (Type, Print)

HELENE MANKOWITZ/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8328 RAYMOND LANE POTOMAC, MD. 20854

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEM. GARDENS

Date

11/8/96

20c. Location - City or Town, State

FALLS CHURCH, VA

21. Signature of Funeral Service Licensee

Paul L. Lyson

22. Name and Address of Facility

IVES-PEARSON FUNERAL HOME
472 N. WASHINGTON ST. FALLS CHURCH, VA 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR DISEASE

YEARS

Due to (or as a consequence of):

b. DIABETES MELLITUS

YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BULLOUS PEMPHIGOID

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28i. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven Lyson MD

29c. License number

D 05885

29d. Date signed (Month, Day, Year)

11/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE MD

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34595

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leonora Walker Hinrichs

2. Date of Death

Month Day Year
Nov. 7, 1996

3. Time of Death

1:45 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

14994 Bushy Park Drive

4b. City, Town, or Location of Death

Woodbine

4c. County of Death

Howard

5. Social Security Number

219-01-3681

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 9, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14994 Bushy Park Road

10f. Zip Code

21797-8318

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Paul F. Needling

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Mary Van Valkenburg

19a. Informant's Name/Relationship (Type, Print)

Joseph Walker, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3735 Beech Avenue Baltimore, Maryland 21211

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

11/9/96

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss Funeral Home

3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Chronic Mitral Regurgitation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hyperlipidemia
Pt recently s/p x3 V CABG
and mitral Valve repair

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D39178

29d. Date signed (Month, Day, Year)

11/8/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Otto MD 10298 B Baltimore National Pike, Ellicott City MD

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John A. Anderson-Randall

21042

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34596

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLORIA Hill

2. Date of Death

11 15 96

3. Time of Death

0125

4a. Facility Name, (If not institution, give street and number)

SINAI HOSPITAL OF BALTO

4b. City, Town, or Location of Death

Balto.

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

213070541

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

8/15/47

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3700 1/2 Columbus Drive

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Benhamin Hill

18. Mother's Name (First, Middle, Maiden Surname)

Annie Mae Riddick

19a. Informant's Name/Relationship (Type, Print)

Ethel Alston/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3700 1/2 Columbus Dr. Balto., MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Memorial Pk

Date

11/20

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home
1701 Laurens St. BALTO., MD 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Suspected Myocardial infarction.

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

N.A.

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Frederick W. Randolph, MD

29c. License number

D19085

29d. Date signed (Month, Day, Year)

November 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital Emergency Frederick W. Randolph M.D.

31. Date filed (Month, Day, Year)

November 15, 1996

32. Registrar's Signature

NOV 15 1996 Julia Davidson-Randolph

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
505a.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 17,5 11-20-96 FilmG741 W.H.Per F/H
State of Maryland / Department of Health and Mental Hygiene

96 34597

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Margaret Louise Harris | | | | 2. Date of Death
Month November Day 14 , Year 1996 | | 3. Time of Death
6:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
3215 Normount Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
241-74-8287 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 1, 1948 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3215 Normount Avenue | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Registered Nurse | | 16b. Kind of Business/Industry
Kernan Hospital | | | |
| | 17. Father's Name (First, Middle, Last)
William Pailin | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Brooks | | 19a. Informant's Name/Relationship (Type, Print) husband
Frank Harris | | | |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3215 Normount Avenue Baltimore, MD 21216 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | 20c. Location - City or Town, State
Nov 18 Catonsville, Maryland | |
| | 21. Signature of Funeral Service Licensee
Mary L. Hollins | | 22. Name and Address of Facility
Nutter Funeral Homes, Inc.
2501 Gwynns Falls Parkway
Baltimore, Maryland 21216 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Congestive heart failure
Due to (or as a consequence of):
b. Primary amyloidosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
11 months
1 year | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Asthma | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Emily S. Fairchild MD | | 29c. License number
D30160 | | 29d. Date signed (Month, Day, Year)
11/15/96 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
419 West Redwood St. Baltimore, Md 21201 | | 31. Date filed (Month, Day, Year)
11/15/96 | | 32. Registrar's Signature
NOV 19 1996 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34598

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD R. HESTER

2. Date of Death
Month Day Year
NOVEMBER 18, 1996

3. Time of Death

12:50AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

266-03-4876

8. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

9-20-1920

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3900 N. Charles ST., Apt. 1307

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Passenger Div. Manager

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

unknown

Hester

18. Mother's Name (First, Middle, Maiden Surname)

Bessie (unknown)

19a. Informant's Name/Relationship (Type, Print)

Sally J. Hester/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3900 N. Charles St., Apt. 1307, Baltimore MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 11-19 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. J. R.

22. Name and Address of Facility

Henry W. Jenkins & Sons Co.

4905 York Rd., Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

- Lung abscess

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Post obstructive pneumonia

Due to (or as a consequence of):

1 month

c. Bronchogenic carcinoma

Due to (or as a consequence of):

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cancer base of tongue

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eugene A. OBA+1

29c. License number

D444018

29d. Date signed (Month, Day, Year)

11/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GBMC

EUGENE

A. OBA+1

6701 Charles St Towson, MD 21204

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia R. Wilson-Randall

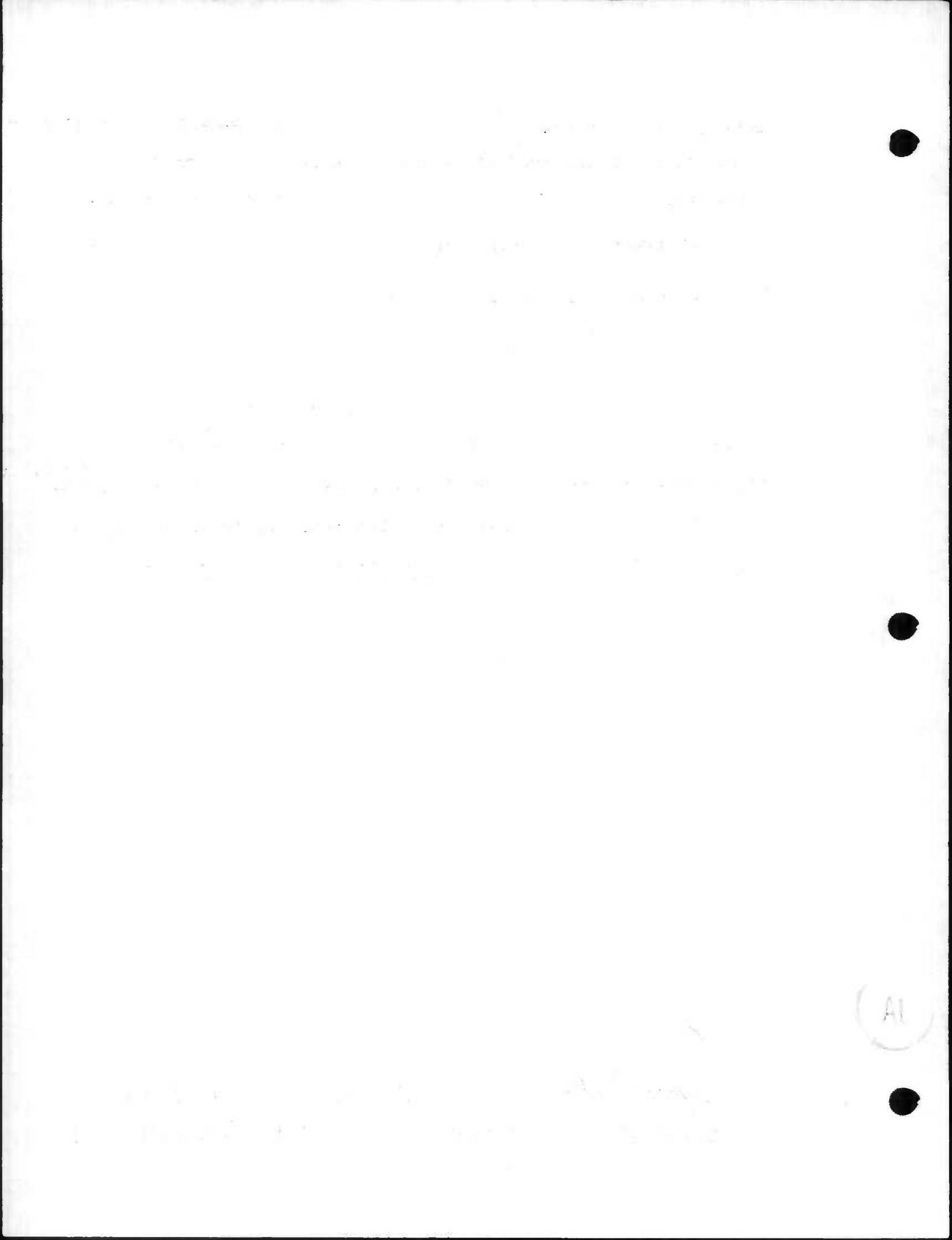
State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34599

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN L. JOYCE

2. Date of Death

Month Day Year
Nov. 18 1996

3. Time of Death

10:15 P.M.

4e. Facility Name (If not institution, give street and number)

1107 William Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

Funeral
Director

5. Social Security Number

705-03-8039

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 24 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1107 William Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Office

16b. Kind of Business/Industry

B & O Railroad

17. Father's Name (First, Middle, Last)

Edward T. Joyce

18. Mother's Name (First, Middle, Maiden Surname)

Mollie F. Hall

19a. Informant's Name/Relationship (Type, Print)

Dorothy Joyce/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1107 William Street Baltimore, Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

NOV 21
1996

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Eugene J. Easton

22. Name and Address of Facility

MCCully Funeral Home of South Balto.
130 E. Fort Ave. Baltimore, Md. 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebral Infarction

Due to (or as a consequence of):

b. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hemorrhagic Cystitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. Davidson - Attending Physician

29c. License number

D26203

29d. Date signed (Month, Day, Year)

11/19/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jorge Vallecillo, MD 1319 Light St Baltimore 21230

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
important: if item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

to the hospital or attending physician: The law requires that the death certificate be executed
within 48 hours after death.
The Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34600

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Exzora Johnson | | | | 2. Date of Death
Month 11 Day 14 Year 96 | | | | 3. Time of Death
10:10pm | |
| | 4a. Facility Name (If not institution, give street and number)
2026 Cliftwood Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
218-18-8662 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB.05,1921 | | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
BAKTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
2026 CLUFTWOOD AVENUE | | | | 10f. Zip Code
21213 | |
| | 10g. Citizen of What Country?
UNITED STATES | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 th College (1-4or 5+) - | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
custodian | | | | 16b. Kind of Business/Industry
BALTO. CITY SCHOOL | | | | 17. Father's Name (First, Middle, Last)
LURENZA JOHNSON | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Sumama)
FRANCES WARNER | | | | 19a. Informant's Name/Relationship (Type, Print)
VERONICA JOHNSON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2026 CLIFTWOOD AVENUE, BALTIMORE, MD#13 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. CALVARY CEMETERY | | | | 20c. Location - City or Town, State
11-19 ANNE ARUNDEL co., | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Baltimore, Maryland
WM.C. March FH 1101 E. North Avenue 21202 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. anorexia
Due to (or as a consequence of):
b. ascites
Due to (or as a consequence of):
c. poorly differentiated hepatocellular carcinoma
Due to (or as a consequence of):
d. | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
D0050772 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
November 15, 1996 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. David Symer, Johns Hopkins Oncology Center, 600 North Wolfe St., Baltimore, MD 21205 | | | | 31. Date filed (Month, Day, Year)
NOV 19 1996 | |
| | 32. Signature of State Registrar
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERMAN

H.

JACKSON

2. Date of Death

Month

Day

Year

NOVEMBER 16, 1996

3. Time of Death

7:10A.M.

4a. Facility Name (If not institution, give street and number)

2418 FRANCIS STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

143-40-7407

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 6 1947

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2418 FRANCIS STREET

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Ella Bagley/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2418 Francis St., Baltimore Maryland 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOUNT ZION CEMETERY

Date

11-21

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H
1206 W. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

NOVEMBER 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R. Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34602

| | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Andrew J. Jones | | | | 2. Date of Death
Month Day Year
Nov 17, 1996 | | 3. Time of Death
8:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
5610 Tramore Road | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-01-8393 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 22, 1916 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Usual Residence of Decedent
10a. State: Maryland 10b. County: N/A 10c. City, Town or Location: Baltimore 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (1-4 or 5+): | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Dispatcher | |
| | 17. Father's Name (First, Middle, Last)
Andrew J. Jones | | 18. Mother's Name (First, Middle, Maiden Surname)
Helene Hurzmann | | 19. Informant's Name/Relationship (Type, Print)
Patricia McCluskey (daughter) | | 20. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | |
| Physician
/Medical
Examiner | 21. Signature of Funeral Service Licensee
<i>A. Alan Seitz, Jr.</i> | | 22. Name and Address of Facility
A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Maryland 21211 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death):
e. <i>Metastatic Adenocarcinoma - unknown primary</i> | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify): | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Davis M. Hahn MD</i> | | 29c. License number
D20396 | | 29d. Date signed (Month, Day, Year)
Nov. 19, 1996 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Davis M. Hahn, 5201 Loch Raven Blvd, Baltimore MD 21239 | | 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 34603**
Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--|---|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RICHARD JONES | | | | | 2. Date of Death
Month 11 Day 15 Year 96 | | 3. Time of Death
2:30 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
VA MEDICAL CENTER | | | | | 4b. City, Town, or Location of Death
FORT HOWARD | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
229-26-2833 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
11-25-23 | | 9. Birthplace (State or Foreign Country)
NC |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
603 CHAPEL GATE LANE | | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1943 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ReUpholstery | | | 16b. Kind of Business/Industry
Monroe Upholstery | | |
| 17. Father's Name (First, Middle, Last)
Tom Jones | | | | | 18. Mother's Name (First, Middle, Maiden Sumame)
Gertrude Knight | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alice Anthony/sister | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2856 W. Mulberry St. Balto., MD 21223 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA | | | Data
11/20 | | 20c. Location - City or Town, State
Owings Mills, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
James A. Morton & Sons Funeral Home
1701 Laurens St. BALTO., MD 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CHOLANGIO CARCINOMA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | | | Approximate interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
045244 | | 29d. Date signed (Month, Day, Year)
11/15/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHANDRAKALA RAJA, M.D., VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34604

| | | | | | | | | |
|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GRACE A. JACOB | | | | 2. Date of Death
Month Nov. Day 11 Year 1996 | | 3. Time of Death
3:55 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
Bon Secours Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-80-1524 | | 8. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 6. Date of Birth (Month, Day, Year)
AUG 13, 1910 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Md. | | | 10b. County
N/A | | | 10c. City, Town or Location
Baltimore | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 10e. Street and Number
349 S. Stricker Street | | | 10f. Zip Code
21223 | | |
| 10g. Citizen of What Country?
USA | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | | 16b. Kind of Business/Industry
Comfy Manufacturing | | | 17. Father's Name (First, Middle, Last)
John Daniel Frye | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Mary E. Carr | | | 19. Informant's Name/Relationship (Type, Print)
Phyllis Jacob - daughter-in-law | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1313 James Street, Baltimore, Md. 21223 | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | | 20c. Location - City or Town, State
11/14/96 Baltimore, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home of Elk., Inc.
5695 Main St., Elkridge, Md. 21227 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ischemic cardiomyopathy
Due to (or as a consequence of):
b. coronary artery disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
End stage Renal Disease | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier

JUAN A. BELTRAN MD | | | 29c. License number
D16263 | | | 29d. Date signed (Month, Day, Year)
Nov. 11, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JUAN A. BELTRAN 1940 W. BALT ST., BALT, MD 21223 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34605

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NELLIE M. KERR

2. Date of Death

November 16 1996

3. Time of Death

10:15 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

248-01-8484

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

November 20, 1903 South Carolina

9. Birthplace (State or Foreign Country)

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2618 Marbourne Avenue

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

J.W. McCurry

18. Mother's Name (First, Middle, Maiden Surname)

Anne M. Campbell

19a. Informant's Name/Relationship (Type, Print)

Michael Kidd (Grandson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

907 Rambling Drive Balto., Md. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Cemetery

Date

11/19/96 Glen Burnie, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home of Brooklyn
237 E. Patapsco Ave. Balto., MD. 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Due to (or as a consequence of):

SEPSIS

Approximate
Interval Between
Onset and Death

10 DAYS

b.

Due to (or as a consequence of):

URINARY TRACT INFECTION

11 DAYS

c.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D47861

29d. Date signed (Month, Day, Year)

NOVEMBER 16, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOSEPH BUATENS MD NORTH ARUNDEL HOSP. GLEN BURNIE, MD

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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20761401

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34606

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin I Kohlepp

2. Date of Death

Month

Day

Year

November 17 1996

3. Time of Death

9:10 am

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-16-6602

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 13, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

199 Margate Drive

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No NAVY
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Albert Kohlepp

18. Mother's Name (First, Middle, Maiden Surname)

Corra Schriever

19a. Informant's Name/Relationship (Type, Print)

ANNA E. Kohlepp / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

199 Margate Drive, Glen Burnie MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Crownsville VA Cemetery

Date

NOV. 22, 1996

20c. Location - City or Town, State

Crownsville MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Charles L. Stevens Funeral Home Inc.
1501 E. Fort Avenue Balt. MD 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 month

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Atherosclerosis / Myocardial Infarction

Due to (or as a consequence of):

1 month

c. Atherosclerosis / Abdominal Aortic Aneurysm

Due to (or as a consequence of):

5 yrs

d. Hypertension

20 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Dz, Stroke, Prostate dz

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 17, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Kashima MD Johns Hopkins Hospital Baltimore MARYLAND 21207

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34607

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY A KEARNEY

2. Date of Death

November 14, 1996

3. Time of Death

11:00 AM

4a. Facility Name (If not institution, give street and number)

3705 Ednor Rd.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-30-2757

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3-20-1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
N/A10c. City, Town or Location
Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3705 Ednor Road

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward P. Wall

18. Mother's Name (First, Middle, Maiden Surname)

Julia M. Burke

19a. Informant's Name/Relationship (Type, Print)

William G. Kearney (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3705 Ednor Road, Baltimore, Maryland 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery 11-18-96

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Wallace S. Brooks, Jr.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Road, Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC HEART DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC VASCULAR DISEASE

Due to (or as a consequence of):

15 yrs

c. HYPERCHOLESTEROLEMIA

Due to (or as a consequence of):

20 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

ANGINA PECTORIS

S/P CABG

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George W. Moran, M.D.

29c. License number

D17346

29d. Date signed (Month, Day, Year)

Nov 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE W. MORAN, MD. UNION MEMORIAL HOSPITAL, BALTO, MD 21218

31. Date filed (Month, Day, Year)

NOV 19 1996

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34608

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Wilkinson King

2. Date of Death

November 18 1996

3. Time of Death

0955 A.

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

228-34-6573

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07-26-1929

9. Birthplace (State or Foreign Country)

WASH., D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

501 WEST UNIVERSITY PARKWAY

10f. Zip Code

21210

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 PLUS

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CHURCH ORGANIST

16b. Kind of Business/Industry

MUSIC

17. Father's Name (First, Middle, Last)

EUGENE WILKINSON KING

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY FINCH

19a. Informant's Name/Relationship (Type, Print)

ELLEN B. KING (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 WEST UNIVERSITY PKWY, BALTO., MD., 21210

20a. Method of Disposition

1 ☐ Burial ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GREEN MOUNT CREMATORY

Date

11-19-96 BALTO., MD. 21202

21. Signature of Funeral Service Licensee

R. J. R.

22. Name and Address of Facility

HENRY W. JENKINS AND SONS COMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Multisystem Failure

Due to (or as a consequence of):

24 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Acute Myocardial Infarction

Due to (or as a consequence of):

24 hours

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

10 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension, cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. J. R.

29c. License number

A72438946

29d. Date signed (Month, Day, Year)

November 18, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Nelly C. Baez 2016 University Parkway, BALTIMORE, MD 21218

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John Davidson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 34609

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
DORMA JEAN KRIFCHIN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOV. 11 1996 | | 3. TIME OF DEATH
8:12 PM | |
| 4. SOCIAL SECURITY NUMBER
233-44-0483 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
DEC. 13, 1931 | |
| 8. BIRTHPLACE (State or Foreign Country)
WV | | | | 9a. FACILITY NAME (If not institution, give street and number)
5727 HARPERS FARM ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH
COLUMBIA | |
| 9c. COUNTY OF DEATH
HOWARD | | | | 10a. STATE
MD | | 10b. COUNTY
HOWARD | |
| 10c. CITY, TOWN OR LOCATION
COLUMBIA | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
5727 HARPERS FARM ROAD | |
| 10f. ZIP CODE
21044 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CUSTOMER SERVICE SUPERVISOR | | 16b. KIND OF BUSINESS/INDUSTRY
RETAIL | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES ERNEST ARTHUR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
GLADYS MEADOR | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CAROLYN KRIFCHIN (DAUGHTER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5727 HARPERS FARM Rd. COLUMBIA, MD 21044 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Chesapeake Crematory NOV. 12, 1996 | | 20c. LOCATION — City or Town, State
BELTSVILLE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Robert Gregory Buhon</i> | | | | 22. NAME AND ADDRESS OF FACILITY
WITZKE FUNERAL HOMES, INC.
5555 TWIN KNOLLS Rd. COLUMBIA, MD 21045 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Cancer
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
emphysema | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
a <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. C. P. ... MD</i> | | | | 29c. LICENSE NUMBER
D22527 | | 29d. DATE SIGNED (Month, Day, Year)
Nov. 12 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
GARY C. ... 11055 Little Patuxent Columbia, Maryland | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 19 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34610

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Andrew John Kram, Jr.

2. Date of Death

November 9, 1996

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

2965 Liberty Parkway

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-40-3549

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 19, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2965 Liberty Parkway

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver Training

16b. Kind of Business/Industry

Training Transportation

17. Father's Name (First, Middle, Last)

Andrew J. Kram, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rose M. Tokunaga

19a. Informant's Name/Relationship (Type, Print)

Andrew J. Kram, Sr. / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

507 S. 45th Street Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Ht. of Jesus Cem. 11/13/96 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic ischemic myocardial disease

Approximate Interval Between Onset and Death

3 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Crossan O'Donovan M.D.

29c. License number

D07632

29d. Date signed (Month, Day, Year)

Nov. 11, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Crossan O'Donovan, M.D. 2112 Dundalk Avenue Dundalk, Maryland 21222

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020. The law requires that the death certificate be executed within 24 hours after death. To the funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1000

1000

1000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34611

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ovid Laten Lewis

2. Date of Death

Month Day Year
NOVEMBER 9 1996

3. Time of Death

0305

4e. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

5. Social Security Number

236-40-5682

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 19, 1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3623 Hickory Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Noxell

17. Father's Name (First, Middle, Last)

Lamard Laten Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Jane Boggs

19a. Informant's Name/Relationship (Type, Print)

Minnie Mae Lewis (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3623 Hickory Avenue Baltimore, MD 21211

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Grdn 11/13/96 Cockeysville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lynn B. Henss

22. Name and Address of Facility

Burgee-Henss Funeral Home
3631 Falls Road Baltimore, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPOXIA SECONDARY TO END STAGE CHRONIC

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

7 YEARS

c. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NON SMALL CELL CARCINOMA OF THE LUNG

CONGESTIVE HEART FAILURE

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accidental ☐ Could not be determined
☐ Suicidal ☐ Homicidal

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lynn B. Henss, MD

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

November 9, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Linda Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 34612**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CALEB, L., MYER

2. Date of Death

Month Day Year
 NOVEMBER 16 96

3. Time of Death

9:24 pm

4a. Facility Name (If not institution, give street and number)

UMMS

4b. City, Town, or Location of Death

Balt.

4c. County of Death

City

Funeral
Director

5. Social Security Number

178-24-1846

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT. 21 1926

9. Birthplace (State or Foreign Country)

Penna.

Usual Residence of Decedent

10a. State

Md.

10b. County

City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4 East Cross Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married

☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates

Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Tavern

17. Father's Name (First, Middle, Last)

Ira Myer

18. Mother's Name (First, Middle, Maiden Surname)

Nettie Landis

19a. Informant's Name/Relationship (Type, Print)

Tracey Myer/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2270 York Road Jamison, Penna 18929

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stumptown Mennonite Church Cemetery

Date

NOV 21 1996

20c. Location - City or Town, State

Bird-in-Hand Penna Lancaster County

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully Funeral Home of South Balto. 130 E. Fort Ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC BRAIN INJURY

Due to (or as a consequence of):

b. ASTHMA ATTACK

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending Investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark M. Kim, MD

29c. License number

08733

29d. Date signed (Month, Day, Year)

11/16/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK M.S. KIM, MD UMMS 22 S. Greene St. BALTIMORE, MD

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

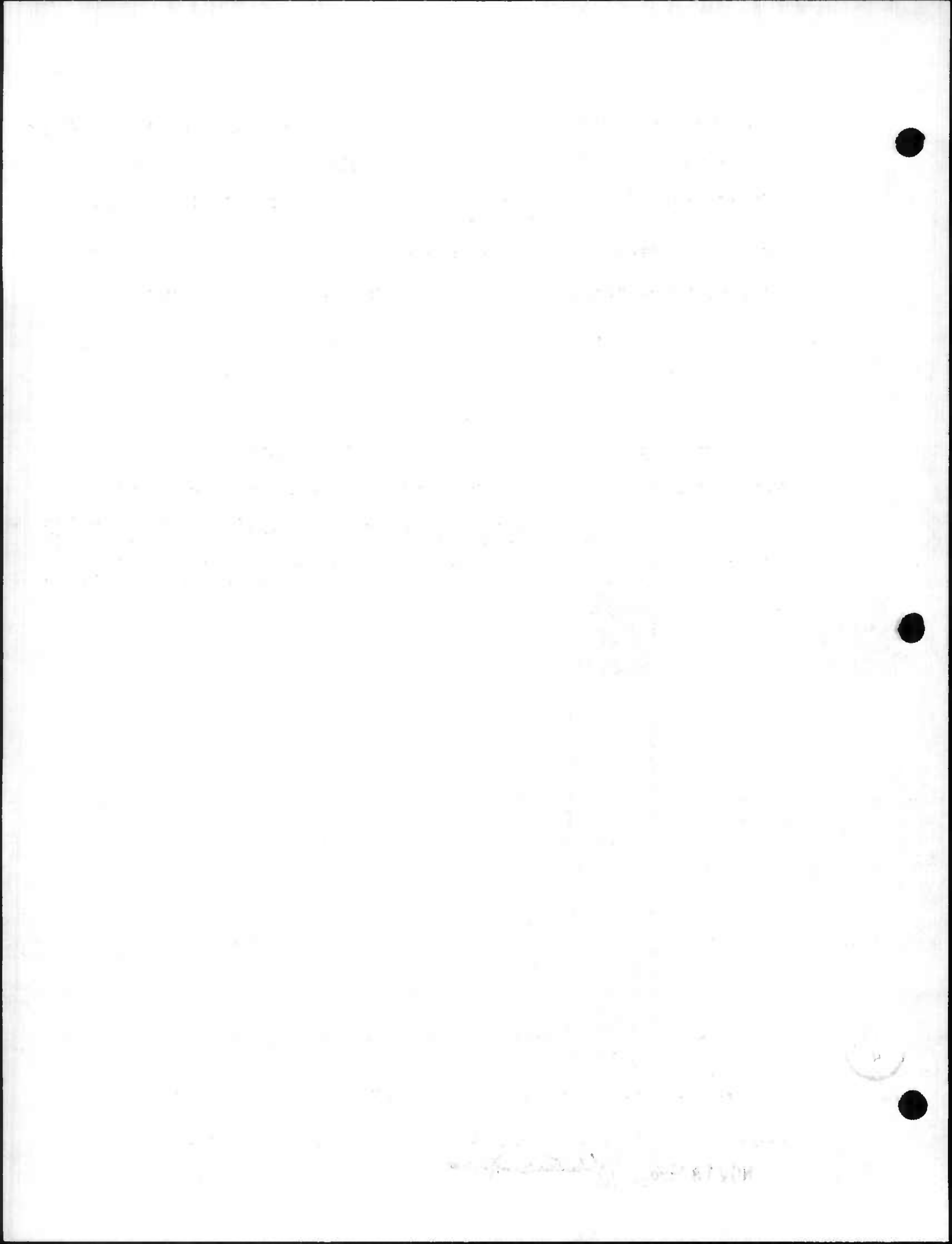
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34613

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JASON E. MILEY

2. Date of Death

Nov. 17 1996

3. Time of Death

0408

4a. Facility Name (If not institution, give street and number)

8610 WILLOW OAK ROAD

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore Co.

5. Social Security Number

220-94-8539

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

21 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 14 1975

9. Birthplace (State or Foreign Country)

Balto. Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8610 Willow Oak Rd.

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Date: 8/9/94/95

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

graphic artist

16b. Kind of Business/Industry

Cisco

17. Father's Name (First, Middle, Last)

John T. Miley

18. Mother's Name (First, Middle, Maiden Surname)

Sharon D. Hawkins

19a. Informant's Name/Relationship (Type, Print)

Sharon D. Hawkins/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1845 Merritt Blvd. Baltimore Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Pk.

Date

NOV. 20 1996

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

Edward Lewis

22. Name and Address of Facility

McCully Funeral Home of Pasadena

3204 Mountain Road Pasadena, Md. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asphyxia and hanging

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

immediate

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

NOV 17, 1996

28b. Time of Injury

0408 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Self-inflicted

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8610 Willow Oak Rd, Balto. Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21204

29b. Signature and title of certifier

J. Crossan Donovan, M.D.

29c. License number

D07632

29d. Date signed (Month, Day, Year)

NOV 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Crossan Donovan, M.D. 2112 DUNDALK AVE BALTO MD 21222

31. Date filed (Month, Day, Year)

NOV 19 1996

Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
obtained from the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

APPENDIX A
List of references

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34614

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE CECILIA MALLONEE

2. Date of Death
Month Day Year

NOVEMBER 15 96

3. Time of Death
3:15 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

219-32-0038

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 3, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4812 Pennington Avenue

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4or 5+)

0

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Book Keeper

16b. Kind of Business/Industry

Curtis Bay Super Market

17. Father's Name (First, Middle, Last)

John J. Belada Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Puncchar

19a. Informant's Name/Relationship (Type, Print)

Bessie Johnson (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4812 Pennington Ave. Balto., MD. 21226

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date
NOV. 18
1996

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McCully Funeral Home of Brooklyn
237 E. Patapsco Ave. Balto., MD. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. UROSEPSIS WITH ACUTE ON CHRONIC RENAL FAILURE

Approximate interval between Onset and Death

8 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

ATRIAL FIBRILLATION

ATHEROSCLEROSIS CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] RESIDENT INTERNAL MEDICINE

29c. License number

2441614 - 39

29d. Date signed (Month, Day, Year)

NOVEMBER 15 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIN MIN THE HARBOR HOSPITAL CENTER 3001 SOUTH HANOVER STREET, BALTIMORE MD 21225

31. Date filed (Month, Day, Year)

NOV 18 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34615

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
Joseph Henry Moss | | | | 2. Date of Death
Month November Day 15 , Year 1996 | | 3. Time of Death
5:10 AM | |
| 4a. Facility Name (If not institution, give street and number)
Hamilton Nursing Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| 5. Social Security Number
212-05-8002 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 7, 1906 | |
| 9. Birthplace (State or Foreign Country)
Illinois | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
4108 St. Thomas Avenue | | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th grade College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Inspector of Oil Tankers | | 16b. Kind of Business/Industry
Baltimore City Oil Tankers | |
| 17. Father's Name (First, Middle, Last)
Peter Moss | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosa Wehren | | | |
| 19a. Informant's Name/Relationship (Type, Print)
William F. Moss (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6929 Standish Drive, Hyattsville, Maryland 20784 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Memorial Gardens | | Date
11-18 | | 20c. Location - City or Town, State
Bel Air, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Schmunek Funeral Home
3331 Brehms Lane, Baltimore, Maryland 21213 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death
DAYS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
N/A | | 28b. Time of Injury
N/A M | | 28c. Injury at Work?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred
N/A | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
N/A | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
N/A | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D34952 | | 29d. Date signed (Month, Day, Year)
11/15/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN T. EVELIUS 5444 BELAIR RD SUITE A BALTIMORE MD 21206 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34616

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PETER LEO MESSINA

2. Date of Death

November 14, 1996

3. Time of Death

10:00 a.m.

4a. Facility Name (If not institution, give street and number)

1832 Susquehanna Hall Road

4b. City, Town, or Location of Death

Whiteford

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

216-01-2027A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 28, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Whiteford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1832 Susquehanna Hall Road

10f. Zip Code

21160

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Marine Engineer

16b. Kind of Business/Industry

Marine Industry

17. Father's Name (First, Middle, Last)

Anthony Messina

18. Mother's Name (First, Middle, Maiden Surname)

Rosalie Anello

19a. Informant's Name/Relationship (Type, Print)

Margaret Messina (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1832 Susquehanna Hall Road, Whiteford, MD. 21160

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Crematory

Date

11/16/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Renal cell cancer

Approximate
Interval Between
Onset and Death

1 year

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

028339

29d. Date signed (Month, Day, Year)

November 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA FRIEDICH 101 E. Wheel Road Bel Air MD 21011

31. Date filed (Month, Day, Year)

NOV 19 1996

Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34617

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE C McLAREN

2. Date of Death

Month
November

Day
14

Year
1996

3. Time of Death

11:40 AM

4a. Facility Name (If not institution, give street and number)

MERCY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

122-03-8960

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 25, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8128 Bullneck Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Office

17. Father's Name (First, Middle, Last)

Louis Lapacek

18. Mother's Name (First, Middle, Maiden Surname)

Emma Tavik

19a. Informant's Name/Relationship (Type, Print)

Emily Denning (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8128 Bullneck Road, Baltimore, Maryland 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green mount Crematory

Date

11-18

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P09761

29d. Date signed (Month, Day, Year)

NOVEMBER 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARNEL M. TAGLE, MD, UNIVERSITY OF MARYLAND MEDICAL SYSTEM, 22 SOUTH GREENE STREET, BALTIMORE, MD

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

21201

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34618

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CORNELL MACK | | | | 2. Date of Death
Month NOVEMBER Day 8 Year 1996 | | 3. Time of Death
11:30pm | |
| | 4a. Facility Name (If not institution, give street and number)
2405 BRIDGE HAMPTON DR. apt. J | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
218-44-9202 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 13, 1948 | |
| | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD | | 10e. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
2405 BRIDGE HAMPTON DRIVE apt. J | | 10f. Zip Code
21234 | |
| | 10g. Citizen of What Country?
UNITED STATES | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
10th | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | | | 16b. Kind of Business/Industry
various trades | | 17. Father's Name (First, Middle, Last)
HARRY EPPES | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
LOUISE MACK | | | | 19a. Informant's Name/Relationship (Type, Print)
HARRY EPPES | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1309 WALTERS AVE., BALTIMORE, MD 21239 | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GREENMOUNT Cem. | | 20c. Location - City or Town, State
11-15-96 BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee
Bernard O. Johnson | | | | 22. Name and Address of Facility
WM. C. MARCHFH.-1101 E. NORTH AVENUE | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cardiomyopathy | | | | | | | |
| | 23f. Immediate Cause (Final disease or condition resulting in death)
Cardiomyopathy | | | | | | | |
| | 23g. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
End stage Renal Disease
Acquired Immunodeficiency Syndrome | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28e. Date of Injury (Month, Day Year) | | | | | | 28f. Time of Injury
M | |
| | 28g. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 28d. Describe how injury occurred | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
[Signature] MD | | | | 29c. License number
D16263 | | 29d. Date signed (Month, Day, Year)
Nov. 14, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JUAN A. PELTRAN, 1940 W. BALT ST, BALT, MD 21223 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | | | | |

0-0-1408

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34619

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Trinita Renee McKoy

2. Date of Death

Month Day Year
11 14 96

3. Time of Death

1:45pm

4a. Facility Name (If not institution, give street and number)

Ravenwood Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Na

Funeral
Director

5. Social Security Number

218-86-1532

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

32

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2-28-64

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2114 Division Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

Na

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerical Worker

16b. Kind of Business/Industry

Monumental Life INS.

17. Father's Name (First, Middle, Last)

Carl J. McKoy Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Butler

19a. Informant's Name/Relationship (Type, Print)

Vimara E. Lawson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2114 Division Street Baltimore, Md. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Mem. PK Cem.

Date

11-19-96 Randallstown, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland

WM.C. March FH 1101 E. North Avenue 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. End stage HIV disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

immediate

> 5 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38637

29d. Date signed (Month, Day, Year)

11/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29 E. Greene St UMMS Baltimore MD 21201

31. Date filed (Month, Day, Year)

NOV 19 1996

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34620

FilmG742 item 5 per FH 12-18-96 rja

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CAROLYN Mary MCPHERSON

2. Date of Death

Month
11Day
13Year
96

3. Time of Death

6:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Dulaney Valley

4c. County of Death

Baltimore

5. Social Security Number

218-40-2786

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan 6, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3901 Marx Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In Own Home

17. Father's Name (First, Middle, Last)

Matthew Mattson

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Hayes

19a. Informant's Name/Relationship (Type, Print)

Patricia N. Tuma

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3803 Cedarhurst Road Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mays Chapel Cemetery

Date

11/16

20c. Location - City or Town, State

Mays Chapel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss Funeral Home

3631 Falls Road Baltimore, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cold Agglutinin Hemolytic Anemia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 mos.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 25643

29d. Date signed (Month, Day, Year)

11.13.96.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H R Faulkner / 2300 Dulaney Valley Rd / Baltimore MD 21204

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

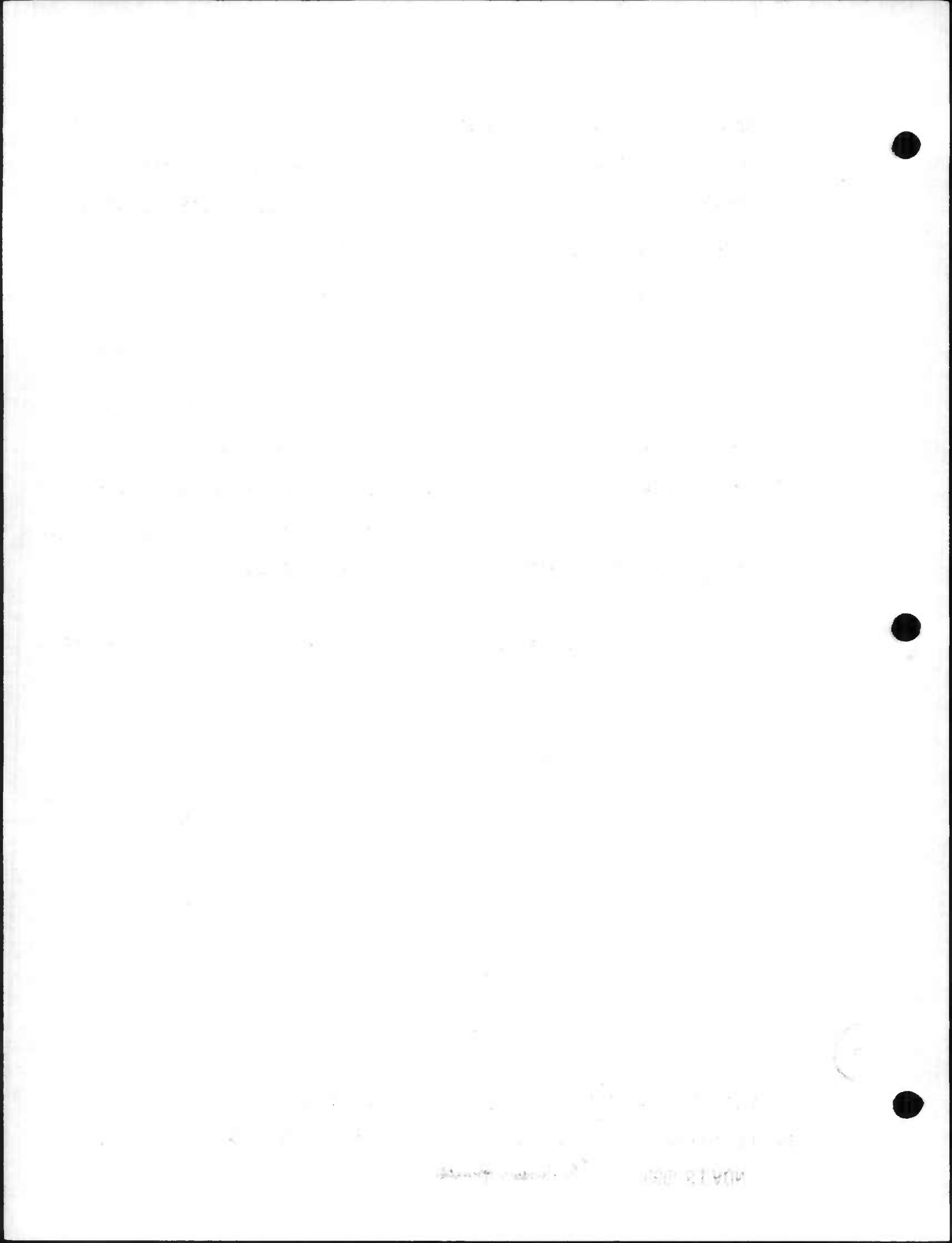
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34621

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Martha K. Merz

2. Date of Death

Month Day Year
Nov. 13, 1996

3. Time of Death

1:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5711 Secound Avenue

4b. City, Town, or Location of Death

Halethorpe

4c. County of Death

Baltimore

5. Social Security Number

217-16-1546

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 11, 1918 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Halethorpe

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

5711 Secound Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Casimir F. Keydash

18. Mother's Name (First, Middle, Maiden Surname)

Martha Milan

19a. Informant's Name/Relationship (Type, Print)

Charlene Reilly, niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4617 Magnolia Avenur Halethorpe, MD 21227

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mausoleum Loudon Park Cemetery 11/16 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc. Arbutus
1328 Sulphur Spring Road 2122723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumonia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

044243

29d. Date signed (Month, Day, Year)

November 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JWCox IV MD 1311 Francis Ave Arbutus MD 21227

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34622

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Osbert X. Moore

2. Date of Death

Month

Day

Year

23:05

4e. Facility Name (If not institution, give street and number)

University of Maryland Medical Center Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

240-96-5100

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

39

8. Date of Birth

If Under 1 Year

If Under 24 Hrs.

Month, Day, Year

9. Birthplace (State or Foreign Country)

N. CAROLINA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1923 W. Lexington St.

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9th

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

CITY

17. Father's Name (First, Middle, Last)

DOUGLASS PRATT

18. Mother's Name (First, Middle, Maiden Surname)

BEATRICE MOORE

19e. Informant's Name/Relationship (Type, Print)

MARY LUCAS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 N. MORLEY ST. BALT. MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST V.A. 11/19/96 Owings Mills MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Funeral Home

GARY D. MARCHE FORD & ASSOC. P.A.
270 FREDERICK PASS BALT. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. gastrointestinal bleeding

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 hours

b. pancreatitis

Due to (or as a consequence of):

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AIDS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P10036

29d. Date signed (Month, Day, Year)

11/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA E. LAZIO UMMS, 22 S. Greene St

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34623

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Louise Moreland

2. Date of Death

Nov 15 1996

3. Time of Death

12:20pm

4a. Facility Name (If not institution, give street and number)

Meridian Spa Creek Nursing Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

217 03 9200

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 2 1914

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

Anne Arundel

10c. City, Town or Location

Galesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4725 Woodfield Rd

10f. Zip Code

20765

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Retail Clerk

16b. Kind of Business/Industry

Sea Food Industry

17. Father's Name (First, Middle, Last)

Herman Albert Woodfield

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Mae Sears

19a. Informant's Name/Relationship (Type, Print)

Laura M. Zang

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4475 Muddy Creek Rd., Harwood, Md 20776

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Woodfield Cemetery

Date

11/18

20c. Location - City or Town, State

Galesville, Md

21. Signature of Funeral Service Licensee

Thomas A. Hardesty

22. Name and Address of Facility

Hardesty Funeral Home, P.A.,
905 Galesville Rd., Galesville, Md 2076523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Right breast cancer
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and DeathApprox.
3 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Right hemiplegic stroke

Pancreatic metastases (versus a primary pancreatic
cancer)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Daniel J. Konick, MD

29c. License number

D32353

29d. Date signed (Month, Day, Year)

11-19-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel J. Konick, MD, 180 Adm. Cochrane Dr., Annapolis, MD 21401

31. Date filed (Month, Day, Year)

NOV 19 1996

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
900.000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34624

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Theodore Charles Mintz

2. Date of Death

Nov 15 1996

3. Time of Death

9:05 am

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

216-34-2603

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1-13-35

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

ELLCOTT CITY

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

4975 ILCHESTER ROAD

10f. Zip Code

21043

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

EDUCATOR

16b. Kind of Business/Industry

DUNLOGGIN MIDDLE SCHOOL

17. Father's Name (First, Middle, Last)

ARTHUR MINTZ

18. Mother's Name (First, Middle, Maiden Surname)

MINNA HARTMANN

19a. Informant's Name/Relationship (Type, Print)

LEA MINTZ (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4975 ILCHESTER ROAD ELLCOTT CITY MD 21043

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

11/18/96

20c. Location - City or Town, State

BELTSVILLE MD

21. Signature of Funeral Service Licensee

R. G. W. J.

22. Name and Address of Facility

WITZKE FUNERAL HOME OF CATONSVILLE, INC.
1630 EDMONDSON AVENUE CATONSVILLE MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Ventricular Arrhythmia

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Atrial Flutter

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Months

Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending
20 Accident investigation
30 Suicide 60 Could not be
40 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
injury28c. Injury at
Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Silverman MD

29c. License number

D41274

29d. Date signed (Month, Day, Year)

Nov 15, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Silverman MD 11085 Little Patuxent Parkway Columbia 21044

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pegs 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

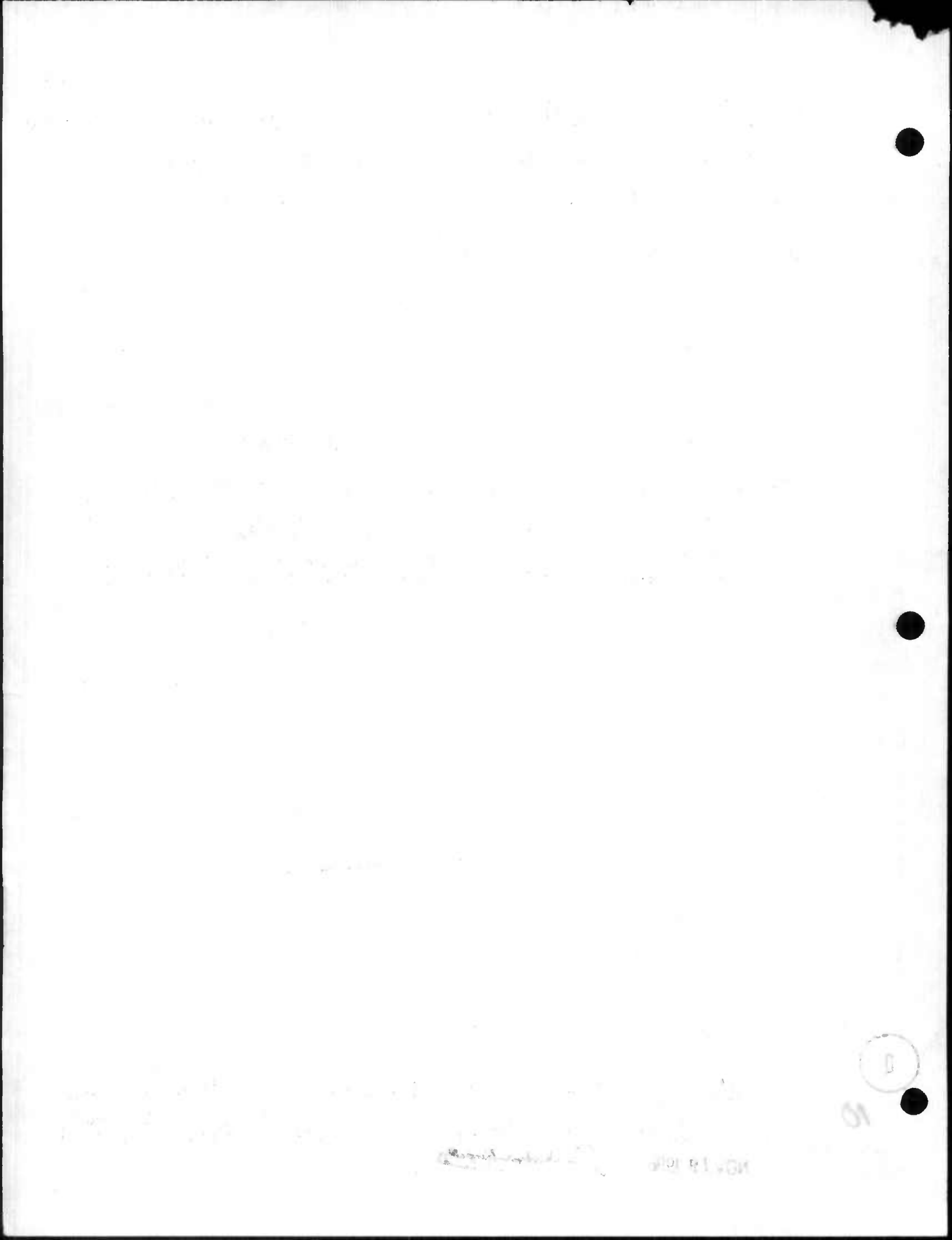
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34625

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNEST NIEDERHAUSER Sr.

2. Date of Death

November 9 1996 2:25 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

City

5. Social Security Number

218-03-9110

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3/3/06

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

209 Waterfountain Court

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Koppers Co.

17. Father's Name (First, Middle, Last)

Henry Niederhauser

18. Mother's Name (First, Middle, Maiden Surname)

Catherine

19a. Informant's Name/Relationship (Type, Print)

Regina Niederhauser/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

209 Waterfountain Ct. Glen Burnie, Md 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Pk. 11/12/96 Glen Burnie, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Eugene J. Costello Jr.

22. Name and Address of Facility

McCully Funeral Home of Pasadena
3204 Mountain Road Pasadena, Md. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

RESPIRATORY FAILURE

Due to (or as a consequence of):

14 DAYS

b.

RECURRENT ASPIRATION PNEUMONIA

Due to (or as a consequence of):

2 MONTHS

c.

DEMENTIA

Due to (or as a consequence of):

> 10 YEARS

d.

ALZHEIMER'S DISEASE

Due to (or as a consequence of):

> 15 YEARS

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PANCYTOPENIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Anthony P. Dasaro M.D.

29c. License number

AS 2441614-50

29d. Date signed (Month, Day, Year)

November 9 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HHC - 3001 S. Hanover Street BALT MD - ANTHONY P. DASARO

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John P. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34626

| | | | | | | | | |
|--|--|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elizabeth Delia NICHOLSON | | | | 2. Date of Death
Month Day Year
November 15, 1996 | | 3. Time of Death
10:00 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rossville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-03-6501 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 4, 1916 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
7604 Old Battle Grove Road | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Yrs. College (14 or 5+) 2 Yr. Business College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
Thomas Clancy | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Bauersfeld | | 19a. Informant's Name/Relationship (Type, Print)
Thomas F. Coffin/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7604 Old Battle Grove Road Dundalk, Maryland 21222 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Pk. Cem. | | 20c. Date
11/19/96 | | 20d. Location - City or Town, State
Middle River, MD | | 21. Signature of Funeral Service Licensee
 | | |
| 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Congestive Heart Failure
Due to (or as a consequence of):

b. Interstitial Lung Disease
Due to (or as a consequence of):

c. Pulmonary Hypertension
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate interval Between Onset and Death
1 month
1 year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Hypertension
Atrial Fibrillation | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | |
| 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
KOTTARATHIL THOMAS JOHN | | 29c. License number
D48206 | | 29d. Date signed (Month, Day, Year)
November 15, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kottarathil, Thomas MD, 9000 Franklin Square Dr. Baltimore MD. 21237 | | 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | | |

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be clearly documented, including the date, amount, and purpose of the transaction. This ensures transparency and allows for easy verification of the data.

2. The second part of the document outlines the procedures for handling discrepancies. It states that any differences between the recorded amounts and the actual amounts must be investigated immediately. The document provides a step-by-step guide for identifying the source of the error and correcting it.

3. The third part of the document describes the process for reconciling accounts. It explains how to compare the internal records with the bank statements to ensure that they match. If there are any differences, the document provides instructions on how to resolve them.

4. The fourth part of the document discusses the importance of regular audits. It states that audits should be conducted at least once a year to ensure that all records are accurate and that the procedures are being followed correctly. The document also provides a checklist for conducting an audit.

5. The fifth part of the document discusses the importance of maintaining confidentiality. It states that all financial information should be kept secure and that only authorized personnel should have access to it. The document provides guidelines for how to handle sensitive information and how to prevent leaks.

6. The sixth part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be clearly documented, including the date, amount, and purpose of the transaction. This ensures transparency and allows for easy verification of the data.

7. The seventh part of the document outlines the procedures for handling discrepancies. It states that any differences between the recorded amounts and the actual amounts must be investigated immediately. The document provides a step-by-step guide for identifying the source of the error and correcting it.

8. The eighth part of the document describes the process for reconciling accounts. It explains how to compare the internal records with the bank statements to ensure that they match. If there are any differences, the document provides instructions on how to resolve them.

9. The ninth part of the document discusses the importance of regular audits. It states that audits should be conducted at least once a year to ensure that all records are accurate and that the procedures are being followed correctly. The document also provides a checklist for conducting an audit.

10. The tenth part of the document discusses the importance of maintaining confidentiality. It states that all financial information should be kept secure and that only authorized personnel should have access to it. The document provides guidelines for how to handle sensitive information and how to prevent leaks.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34627

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NAOMI OSTENDORF | | | | 2. Date of Death
Month NOV Day 14 Year 1996 | | 3. Time of Death
12:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
213-28-2712 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 19, 1916 | 9. Birthplace (State or Foreign Country)
Baltimore, Md. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Kingsville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
7710 Gremecy Park Road | | | | 10f. Zip Code
21087 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th. College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Stenographer | | 16b. Kind of Business/Industry
Paint Company | | |
| 17. Father's Name (First, Middle, Last)
Arthur H. Wanner | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Molly Courtney | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joann Packer (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7710 Gremecy Park Road Kingsville, Md. 21087 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Cemetery Nov. 16, 1996 | | Data | | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
E. F. Lassahn | | | | 22. Name and Address of Facility
E. F. Lassahn Funeral Home
11750 Belair Road Kingsville, Md. 21087 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Multiple Myeloma
Due to (or as a consequence of):
c. Acute Renal Failure
Due to (or as a consequence of):
d.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Julia Davidson-Randall | | 29c. License number
P09764 | | 29d. Date signed (Month, Day, Year)
Nov 14, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROB T TURNER MD DEPT MEDICINE UNIV. of MD. 22 S Greene St. BALTIMORE, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34628

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Naomi, A. Peters

2. Date of Death

Month Day Year
November 11 1996

3. Time of Death

11:14 am

4a. Facility Name (If not institution, give street and number)

Mercy Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

212-12-1310

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 10 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

1806 S. Charles Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife/domestic

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

George W. Hayes

18. Mother's Name (First, Middle, Maiden Surname)

Mary Frances Schlitzky

19a. Informant's Name/Relationship (Type, Print)

John A. Peters, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1806 S. Charles Street Baltimore Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Pk.

Date

Nov. 14 1996

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

David A. Hayes

22. Name and Address of Facility

McCully Funeral Home of South Balto.
130 E. Fort Ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COPD exacerbation

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

2 ☒ Inpatient

3 ☐ ER/Outpatient

4 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Scott Becker, M.D.

29c. License number

P105 49

29d. Date signed (Month, Day, Year)

November 11, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Becker, Mercy Hospital, Baltimore, MD

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Jana Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34629

| | | | | | | | | |
|---|--|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BESSIE MYRTLE PETER | | | 2. Date of Death
Month Day Year
NOVEMBER 12, 1996 | | 3. Time of Death
1:20 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
263-27-4460 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 | | 8. Date of Birth (Month, Day, Year)
July 16 1908 | |
| | 9. Birthplace (State or Foreign Country)
South Carolina | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
TOWSON | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
509 E. Joppa Rd. | | 10f. Zip Code
21204 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
Augustus Turner | | | 18. Mother's Name (First, Middle, Maiden Surname)
Della Putman | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Nancy Lyne Karweit | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26 Theo Lane, Towson, MD 21204 | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
11/13/96 | | 20c. Location - City or Town, State
Catonsville, MD | |
| | 21. Signature of Funeral Service Licensee

Lowell M. Lemmon | | | 22. Name and Address of Facility
Lemmon Funeral Home
10 W. Padonia Rd., Timonium, MD 21093 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

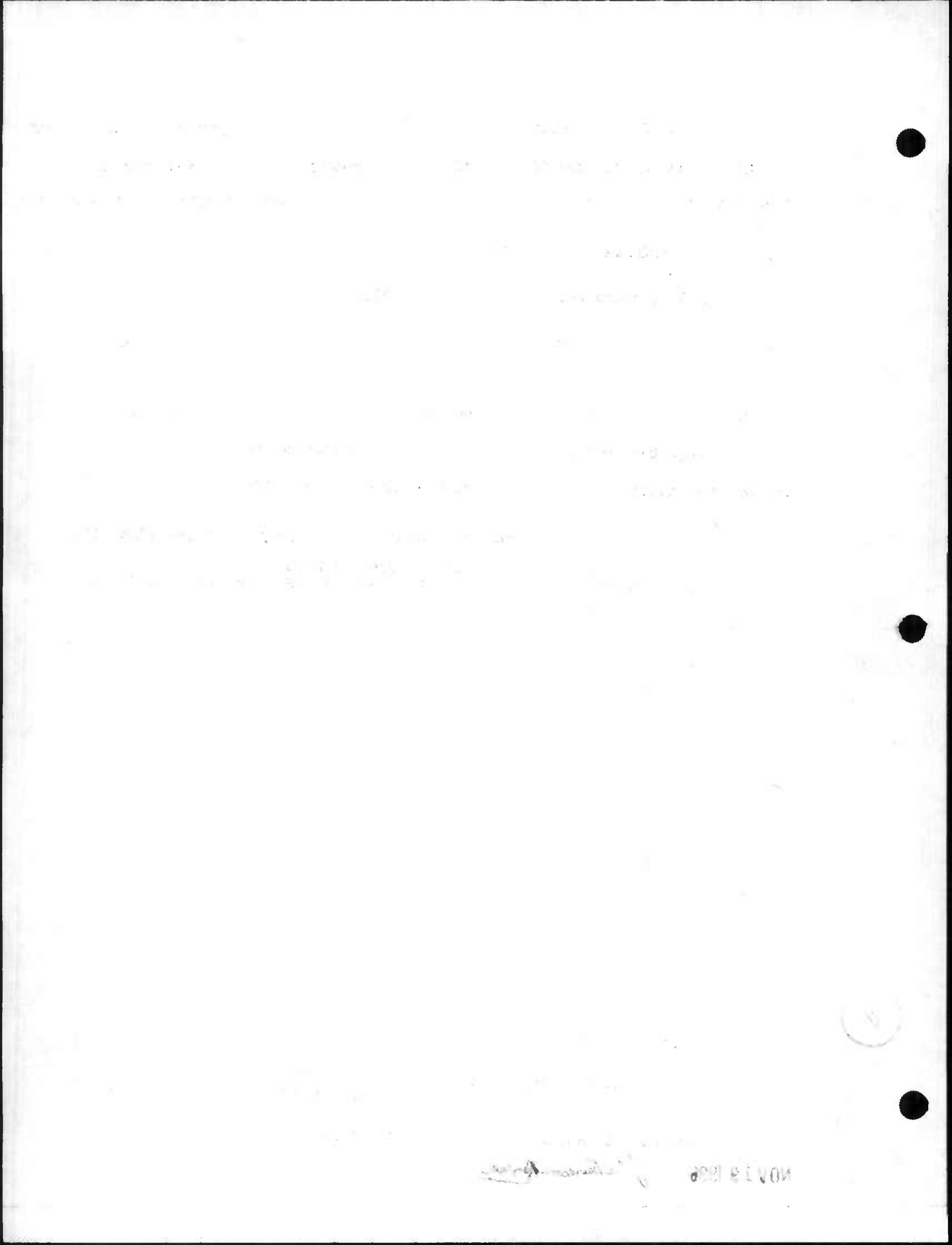
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. E. coli pneumonia
Due to (or as a consequence of):</p> <p>b. diabetes
Due to (or as a consequence of):</p> <p>c.
Due to (or as a consequence of):</p> <p>d.
Due to (or as a consequence of):</p> </div> </div> | | | | | | | Approximate Interval Between Onset and Death
7 days
30 years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
dementia, stroke, right hemiparesis,
1 week after gangrenous cholecystectomy
depression, chronic atrial fibrillation | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
N/A | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D41104 | | 29d. Date signed (Month, Day, Year)
11-12-96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Theodore C. Houk, M.D. GBMC, Towson, MD. 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34630

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DONALD M ROMNEY | | | | 2. Date of Death
Month NOVEMBER Day 17 Year 1996 | | 3. Time of Death
8:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Northwest Hospital Center | | | | 4b. City, Town, or Location of Death
Randallstown | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-09-0854 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 31, 1919 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Lochearn | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3610 Cedar Drive | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Employee Representative | | 16b. Kind of Business/Industry
State of Maryland | | | |
| | 17. Father's Name (First, Middle, Last)
Charles W. Romney | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Jane Chilcoat | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Mary Romney | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3610 Cedar Drive Baltimore, Maryland 21207 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | 20c. Location - City or Town, State
11/20 Woodlawn, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
<i>Stephen M Jenkins</i> | | 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD 21133 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. Chronic Obstructive Lung Disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
<i>[Signature]</i> MD | | | | 29c. License number
D44505 | | 29d. Date signed (Month, Day, Year)
November 17, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A J. Imperial - Northwest Hospital Center | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12



REC'D 11-14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34631

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Viola C. REED

2. Date of Death
Month Day Year

November 8, 1996

3. Time of Death

1:00 p.m.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-03-9366

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Aug. 30, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7615 Wilhelm Avenue

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George S. Sobus

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Skwozynska

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Jordan (dghtr)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7615 Wilhelm Avenue, Baltimore, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stanislaus Cem.

Date

11/12/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Pseudomembranous colitis

Due to (or as a consequence of):

3-4 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Ischemic necrosis of proximal large intestine

Due to (or as a consequence of):

c. Pleural effusions, bilateral, severe

Due to (or as a consequence of):

d. Bronchopneumonia, bilateral, early

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28e. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RD02117

29d. Date signed (Month, Day, Year)

November 9, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. I-Zu Huang 9000 Franklin Square Drive Baltimore, Md. 21237

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 34632

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HELEN RESNICK | | | | 2. DATE OF DEATH
MONTH DAY YEAR
November 7, 1996 | | 3. TIME OF DEATH
9:30 P. M. | |
| 4. SOCIAL SECURITY NUMBER
577-14-6001 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 21, 1919 | |
| 8a. FACILITY NAME (If not institution, give street and number)
10300 Lariston Lane | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | | 8c. COUNTY OF DEATH
Montgomery | |
| 9a. RESIDENCE OF DECEDENT
10a. STATE
Maryland | | | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Silver Spring | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
10300 Lariston Lane | | 10f. ZIP CODE
20903 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years
College (1-4 or 5+) Executive | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Electrical Contractor | | | | 16b. KIND OF BUSINESS/INDUSTRY
Electrical Contractor | | 17. FATHER'S NAME (First, Middle, Last)
Samuel Barney | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Molly Tucker | | | | 19a. INFORMANT'S NAME (Type/Print)
Gerald M. Resnick | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
495 River Forest Drive, Great Falls, Virginia 22066 | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
11/10/1996
Mount Lebanon Cemetery | | 20c. LOCATION — City or Town, State
Adelphi, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Donald C. Stottmeyer | | | | 22. NAME AND ADDRESS OF FACILITY
STEIN HEBREW MEMORIAL FUNERAL HOME, INC.
232 CARROLL ST, NW, WASHINGTON, DC 20012 | | | |
| 23. PART I. Enter the diseases, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29c. SIGNATURE AND TITLE OF CERTIFIER
Barry Rosenbaum, M.D. | | | | 29d. LICENSE NUMBER
109874 | | 29e. DATE SIGNED (Month, Day, Year)
11/8/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 19 1996 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

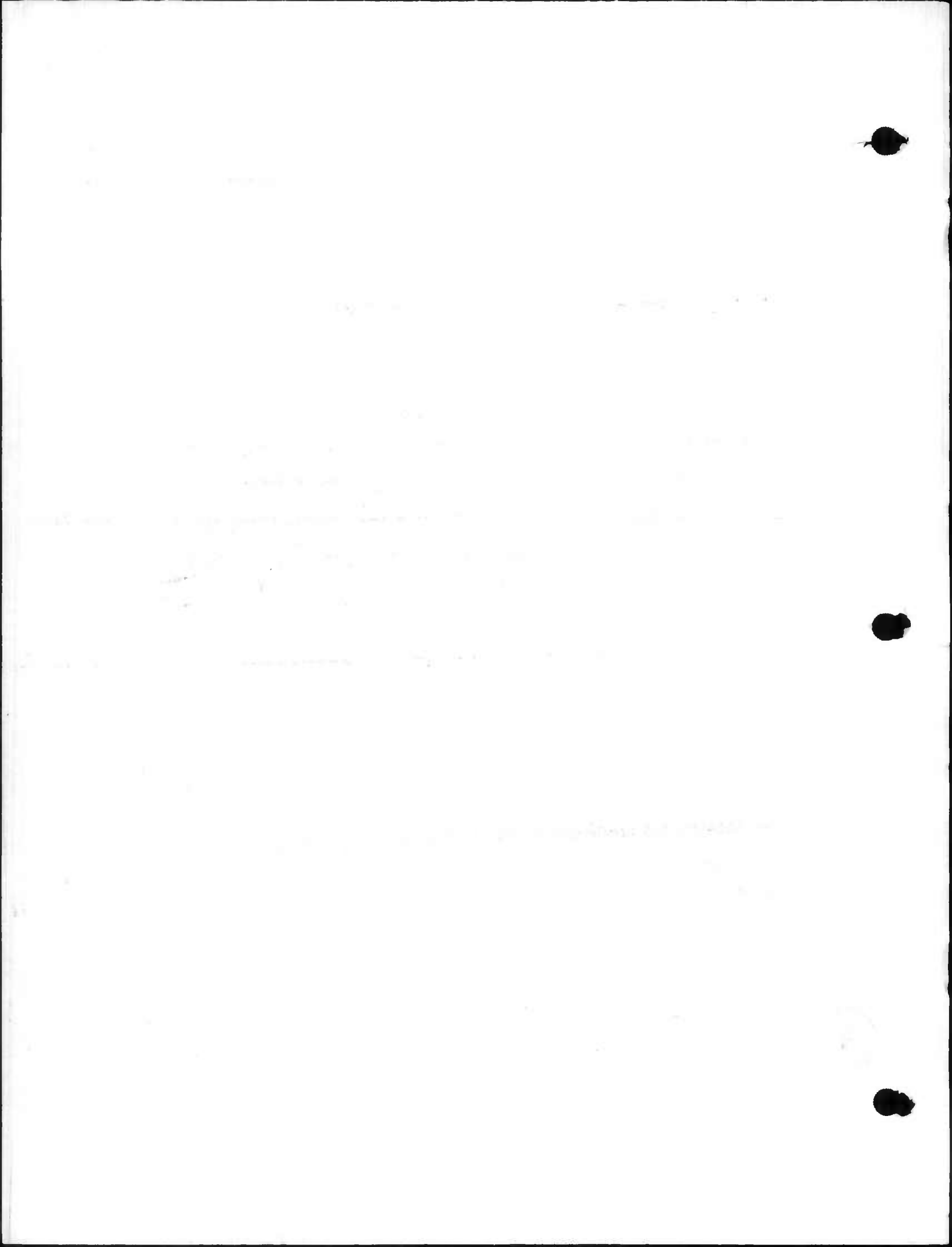
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

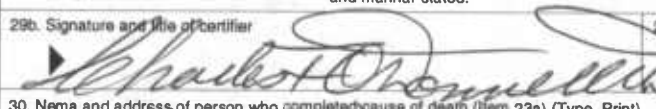

Certificate of Death

96 34633

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KARL RAIDMA | | | | 2. Date of Death
Month Day Year
November 8, 1996 | | 3. Time of Death
7:45 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
7228 Hilltop Ave. | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-34-1639 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 26, 1918 | 9. Birthplace (State or Foreign Country)
Estonia | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Baltimore | 10c. City, Town or Location
Rosedale | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
7228 Hilltop Avenue | | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
Estonia | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Watch Repairman | | 16b. Kind of Business/Industry
Jewelers | | | |
| | 17. Father's Name (First, Middle, Last)
Johann Raidman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Johanna Lind | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Juhan K. Raidma (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7228 Hilltop Ave. Baltimore, Md. 21237 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Faith | | Date
11/15/96 | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Baltimore, Maryland 21214
Leonard J. Ruck, Inc. 5305 Harford Rd. | | | | | |
| | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Cardio Respiratory Failure due to</i>
Due to (or as a consequence of):
<i>Metastatic Lesion from Primary</i>
Due to (or as a consequence of):
<i>Naso Pharyngeal Cancer</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
<div style="border-left: 2px solid black; padding-left: 10px; margin-left: 20px;"> <i>Cardio Respiratory Failure due to</i>
 <i>Metastatic Lesion from Primary</i>
 <i>Naso Pharyngeal Cancer</i> </div> | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of Certifier
 | | 29c. License number
D-09383 | | 29d. Date signed (Month, Day, Year)
11-8-96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles F. O'Donnell MD - 111 Hamlet Hill Rd Md 21210 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar


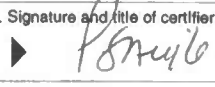

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34634

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BLANCHE RUBINO | | | | 2. Date of Death
Month 11 Day 13 Year 96 | | 3. Time of Death
11:23 PM | |
| | 4a. Facility Name (If not institution, give street and number)
GREATER LAUREL REGIONAL HOSPITAL | | | | 4b. City, Town, or Location of Death
LAUREL | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
235-38-3919 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
94 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
August 3, 1902 | 9. Birthplace (State or Foreign Country)
W. VA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Elkridge | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
6286 Montgomery Rd. | | | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | | 16b. Kind of Business/Industry
own home | |
| | 17. Father's Name (First, Middle, Last)
Louis Harris | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ranty MacWayn | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Steven A. Rubino (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6286 Montgomery Rd., Elkridge, Md. 21227 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Park | | Data
11/16/96 | | 20c. Location - City or Town, State
Elkridge, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home of Elk., Inc.
5695 Main St., Elkridge, Md. 21227 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Pleural Effusion | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death
20 days | | | | | | | |
| 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Pneumonia
Hypoxia
Acute Pulmonary | | | | | | | | |
| 23d. Due to (or as a consequence of):
10-15 days
10-15 days
7 minutes | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier
 MD. | | | | 29c. License number
042580 | | 29d. Date signed (Month, Day, Year)
11-14-96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PS AUSTIN 5632 Annapolis Rd #13 Bladensburg MD 20710. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. 100 20 30 40 50 60 70 80 90 100

10 20 30 40 50 60 70 80 90 100

100 200 300 400 500 600 700 800 900 1000

100 200 300 400 500 600 700 800 900 1000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34635

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shelton

W.

REYNOLDS

2. Date of Death

November 14, 1996

3. Time of Death

2:20 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-20-8652

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 1-1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

19 Juliet Lane Apt. 103

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th grade

N/A

18e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Glass Cutter

16b. Kind of Business/Industry

P.P.G. Industries

17. Father's Name (First, Middle, Last)

Shelton W. Reynolds, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ida Pearce

19a. Informant's Name/Relationship (Type, Print)

Alice Reynolds

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 Juliet Lane Apt. 103 Balto., Md. 21236

20a. Method of Disposition

XX Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

Date

11-18-96

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Lassahn Funeral Home

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Md. 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. AORTIC STENOSIS

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

10 Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE DUE TO GLOMERULONEPHRITIS

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending
20 Accident investigation
30 Suicide 60 Could not be
40 Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?

10 Yes 20 No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34636

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEROY SCOTT

2. Date of Death

November 2, 1996

3. Time of Death

5:00 P.M.

4a. Facility Name (If not institution, give street and number)

3812 Brooklyn Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-01-7135

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 17, 1921

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore City

10c. City, Town or Location

Baltimore (Brooklyn)

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3812 Brooklyn Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

College

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

US Coast Guard Yard

17. Father's Name (First, Middle, Last)

Ernest Scott

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Durham

19a. Informant's Name/Relationship (Type, Print)

Pauline L. Scott (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3812 Brooklyn Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Nov. 6 1996

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully Funeral Home of Brooklyn
237 E. Patapsco Ave. Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEMORRHAGE, CARCINOMA OF LUNG (TERMINAL)
Due to (or as a consequence of):

b. ARTERIOSCLEROTIC HEART DISEASE
Due to (or as a consequence of):

c. CHRONIC OBSTRUCTIVE LUNG DISEASE
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. CARLOS N. PATALINGHUS, MD. 403 E. PATAPSCO AV. 21225

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.

3. The third part is a description of the results
of the study. 4. The fourth part is a discussion
of the results and their implications. 5. The fifth
part is a conclusion and a list of references.

6. The sixth part is a list of references. 7. The
seventh part is a list of references. 8. The eighth
part is a list of references. 9. The ninth part is a
list of references. 10. The tenth part is a list of
references.

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State of Maryland / Department of Health and Mental Hygiene 96 34637
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Helen Virginia Souder | | | | 2. Date of Death
Month November Day 17 , Year 1996 | | 3. Time of Death
11:22 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Charlestown Care Center | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-10-7393 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Aug. 16, 1912 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
709 Maidenchoice Lane | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | |
| 17. Father's Name (First, Middle, Last)
Wilmer B. Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lily Mae (Unknown) | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Melvin C. Souder (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 Mission Court New Braunfels, Texas 78130 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
11/17/96 | | 20c. Location - City or Town, State
Catonsville, MD. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
McCully Funeral Home of Brooklyn
237 E. Patapsco Ave. Balto., MD. 21225 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Causa (Final disease or condition resulting in death)
a. Hypotensive Emergency.
Due to (or as a consequence of):
b. Stroke
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | |
| Approximate Interval Between Onset and Death
days
year | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D47447 | | 29d. Date signed (Month, Day, Year)
November 18, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Lazris 211 Maiden Choice Lane, Catonsville, Maryland 21228 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

100

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State of Maryland / Department of Health and Mental Hygiene

96 34638

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|---|--|--------------------------|---|---|--|---|---|--------------|--|----------------------------------|--------|-----------------|--------|-------------------------------------|--|--|-------------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Pauline SIMMONS | | | | 2. Date of Death
Month Day Year
November 16, 1996 | | | | 3. Time of Death
9:08 am | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
Baltimore County | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
215-74-1001 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 2, 1914 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| | 10e. Street and Number
4804 Hamilton Ave., Apt. 2C | | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (1-4 or 5+) College (1-4 or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
John Frohn | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ernestine Miller | | | | | | | | | | | | | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Joseph A. Simmons | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1308 Lake Vista Drive, Joppa, MD 21085 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial Park | | Date
11/19/96 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Pneumonia</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>Due to (or as a consequence of):</td> <td>2 days</td> </tr> <tr> <td>b. Septic Shock</td> <td>2 days</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | Approximate Interval Between Onset and Death | Due to (or as a consequence of): | 2 days | b. Septic Shock | 2 days | c. Due to (or as a consequence of): | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | d. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | 2 days | | | | | | | | | | | | | | | | | | | |
| | b. Septic Shock | 2 days | | | | | | | | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | d. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
02B717 | | 29d. Date signed (Month, Day, Year)
11/16/96 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Selinger M.D. 9000 Franklin Square Drive Baltimore Maryland 21237 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

13/10/62

048117

Walter J. ...



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34639

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John T. Seidenstricker, Sr.

2. Date of Death

November 14, 1996

3. Time of Death

3:50 AM

4a. Facility Name (If not institution, give street and number)

Lorien Frankford Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-38-6649

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 11, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

155 S. Robinson Street

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Electric Company

17. Father's Name (First, Middle, Last)

Charles Seidenstricker

18. Mother's Name (First, Middle, Maiden Surname)

Alice Winchester

19a. Informant's Name/Relationship (Type, Print)

Jean Seidenstricker (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

155 S. Robinson St., Baltimore, MD 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Crematory

Date

11/15/96 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 2123623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Cardiac Arrest

hours

Due to (or as a consequence of):

b.

Arteriosclerotic Cardiovascular

years

Due to (or as a consequence of):

c.

D-SEN

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gracie X. Datrillo

29c. License number

208318

29d. Date signed (Month, Day, Year)

11/14/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACIE X. DATRILLO

8903 HARTFORD ROAD
BALT. MD 21234

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia Strickland-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34640

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur M. Schmidt, Jr.

2. Date of Death

November 18, 1996

3. Time of Death

3:37 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric & Rehab. Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

214-14-9962

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 6, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7220 Greenbank Road

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

High School Teacher

16b. Kind of Business/Industry

Public High School

17. Father's Name (First, Middle, Last)

Arthur M. Schmidt, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Bauer

19a. Informant's Name/Relationship (Type, Print)

Donald H. Bauer (cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 S. Pine Ridge Ct., Bel Air, MD 21014

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

11/21/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 2123623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. *Cancer of Pancreas - Metas to Colon*Approximate
Interval Between
Onset and Death

2 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. *Cancer of Pancreas*

Due to (or as a consequence of):

1+ years

c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office,
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

714221

29d. Date signed (Month, Day, Year)

11.19.96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. A. FLOWN 223 B Bldg Bldg 21221

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34641

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marion Alexander Snowden | | | | 2. Date of Death
Month 11 Day 3 Year 96 | | 3. Time of Death
11:16 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hosp. | | | | 4b. City, Town, or Location of Death
Balto | | 4c. County of Death
City | |
| Funeral
Director | 5. Social Security Number
220-09-5336 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Apr. 12 1917 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
401 East 25th Street | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U. S. A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Custodian | | 16b. Kind of Business/Industry
Wyman Park Bank | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
William P. Alexander Snowden | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Daisy Smith | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Shirley Clark | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5116 Laurel Ave. Baltimore, Maryland 21215 | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Cemetery | | Date
11-08-96 | | 20c. Location - City or Town, State
Timonium, MD 21202 | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
WM.C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Ruptured Aortic Aneurysm
Due to (or as a consequence of):
b. Repaired Aortic Aneurysm
Due to (or as a consequence of):
c. Atrial Fibrillation
Due to (or as a consequence of):
d. Congestive Heart Failure | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arthritis
Hypertension
Severe Anemia | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| State
Registrar | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 3 | 29b. Signature and title of certifier
 | | | | 29c. License number
D36786 | | 29d. Date signed (Month, Day, Year)
November 15, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jeffrey P. Katz M.D., Union Mem Hosp., Balto, MD | | | | | | | |
| 31. Date filed (Month, Day, Year)
Nov 19 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, PER MED FILM State of Maryland / Department of Health and Mental Hygiene

96 34642

G-741 11/26/96 t.t

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GREGORY | | 2. Date of Death
Month Day Year
NOVEMBER 5, 1996 | | 3. Time of Death
0327AM |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
219-47-8432 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs. 1 Months 19 Days | 8. Date of Birth (Month, Day, Year)
Sept 17 1996 | 9. Birthplace (State or Foreign Country)
S.S., Md. |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Prince Georges | 10c. City, Town or Location
Landover | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
710 Greenwillow Drive | | 10f. Zip Code | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) N/A | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
N/A | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Melvin Spicer | | 18. Mother's Name (First, Middle, Maiden Surname)
Christine Jones | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Christine Jones Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
710 Greenwillow Dr. Landover, Md. | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glenwood Cemetery | | 20c. Location - City or Town, State
Washington, DC |
| | 21. Signature of Funeral Service Licensee
Sharon Johnson-Salley | | 22. Name and Address of Facility
Capitol Mortuary N.E. 1425 Maryland Ave | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
SUDDEN INFANT DEATH SYNDROME
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year)
11-9-96 | | | | | |
| 28b. Time of Injury
M | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Donald G. Wright MD | | | | | |
| 29c. License number
O.C.M.E. | | | | | |
| 29d. Date signed (Month, Day, Year)
NOVEMBER 05, 1996 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | | |
| 32. Registrar's Signature
Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

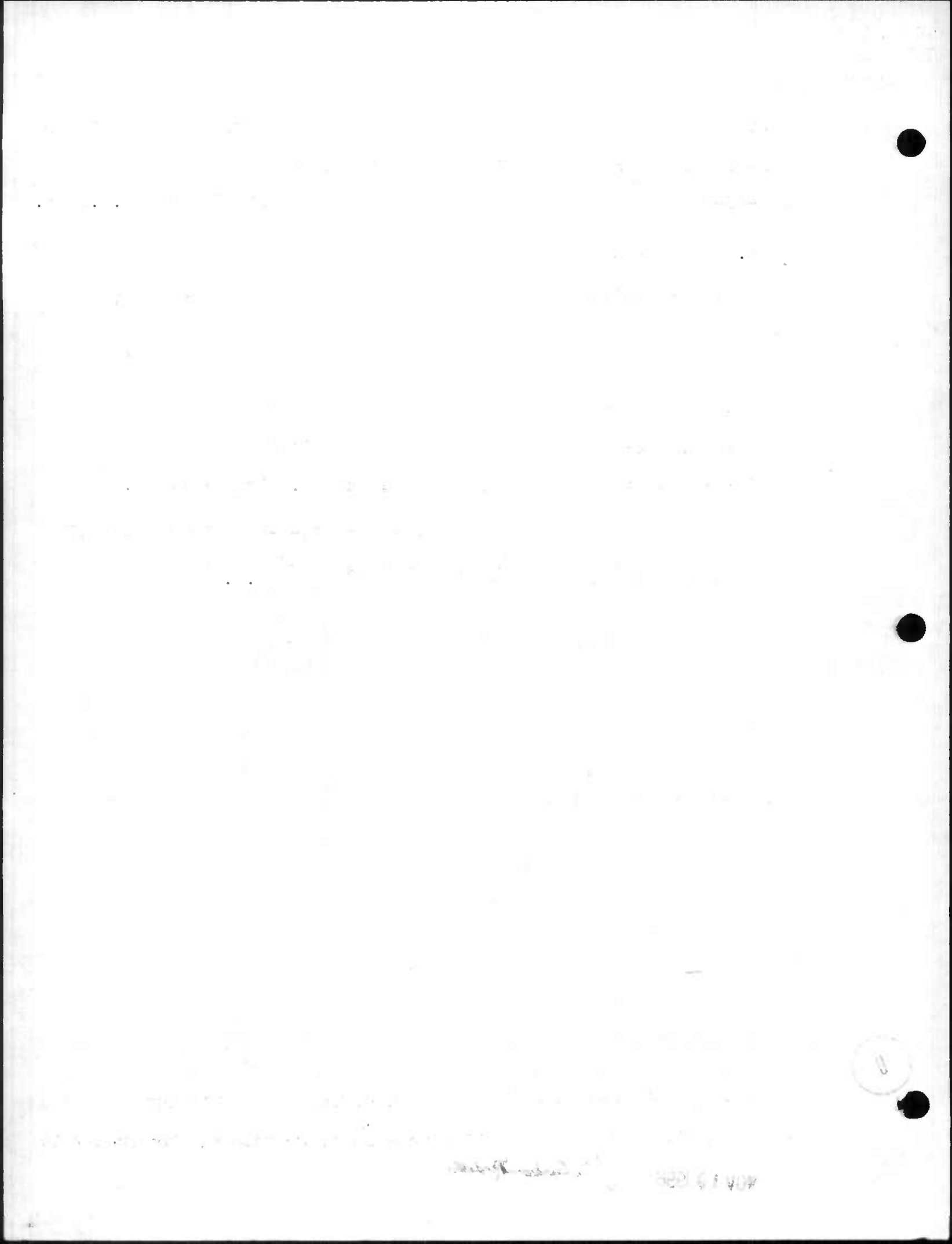
Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34643

ITEM; 5, per F.H. G-741 11/19/96 reb

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Erma Beatrice Schanberger

2. Date of Death

November 12, 1996 10:16 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

22-09-9854

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 26, 1912

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1908 Carrs Mill Road

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Real Estate Agent

16b. Kind of Business/Industry

Henry Fiorini

17. Father's Name (First, Middle, Last)

James Crowther

18. Mother's Name (First, Middle, Maiden Summa)

Fern Lane

19a. Informant's Name/Relationship (Type, Print)

Harry E. Dunkle (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4314 Edro Ave. Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. Nov. 15, 1996

Data

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home
11750 Belair Road Kingsville, Maryland 21087

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE PULMONARY EDEMA

HOURS

Due to (or as a consequence of):

b. ACUTE RENAL FAILURE

DAYS

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JAY M LANG

29c. License number

H44463

29d. Date signed (Month, Day, Year)

NOVEMBER 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAY M LANG, DO 658 BOULTON STREET, BEL AIR, MD 21014

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

hospital or attending physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it will be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34644

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Rosa W. Sebald</i> | | | | 2. Date of Death
Month: <i>Nov.</i> Day: <i>10</i> Year: <i>1996</i> | | 3. Time of Death
<i>07:20 AM</i> | |
| | 4e. Facility Name (If not institution, give street and number)
<i>Charlestown Care Center</i> | | | | 4b. City, Town, or Location of Death
<i>Catonsville</i> | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>217-48-6158</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>94</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>June 6 1902</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>Germany</i> | | 10a. State
<i>Maryland</i> | | 10b. County
<i>Baltimore</i> | | 10c. City, Town or Location
<i>Catonsville</i> | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
<i>Maryland</i> | | | 10b. County
<i>Baltimore</i> | | | 10c. City, Town or Location
<i>Catonsville</i> | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 10e. Street and Number
<i>711 Maiden Choice Lane</i> | | | 10f. Zip Code
<i>21228</i> | | |
| 10g. Citizen of What Country?
<i>USA</i> | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): <i>12</i> College (1-4or 5+): | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | | 16b. Kind of Business/Industry
<i>Homemaking</i> | | | 17. Father's Name (First, Middle, Last)
<i>George Gross</i> | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
<i>Karolina Wengert</i> | | | 19e. Informant's Name/Relationship (Type, Print)
<i>Herbert Hacke / nephew</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5818 East Ave Baltimore, MD 21206</i> | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Lakeview Memorial Park</i> | | | 20c. Location - City or Town, State
<i>11/15 Sykesville MD</i> | | |
| 21. Signature of Funeral Service Licensee
<i>M. Leaf Coleman</i> | | | 22. Name and Address of Facility
<i>HUBBARD FUNERAL HOME, Inc.
4107 Wilkens Ave, Baltimore, MD 21229</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
<i>a. Atherosclerotic Coronary Vascular Disease</i> Approximate Interval Between Onset and Death: <i>2 WKS</i> | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
<i>b. Dehydration & Malnutrition</i> <i>3 WKS</i> | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | |
| 28b. Time of Injury
<i>M</i> | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | | | | | |
| 29c. License number
<i>D34053</i> | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
<i>Nov-10, 1996</i> | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Gary Brilebaum 711 Maiden Choice Lane 21228</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>NOV 19 1996</i> | | | | | | | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1919-1920

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34645

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia K Saylor

2. Date of Death
Month Day Year

11 15 96

3. Time of Death

16:15

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

297-24-0853

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEB 16, 1930

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

502 EAST LYNN AVENUE

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

EXPEDITER

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

COLIN HOFFMAN

18. Mother's Name (First, Middle, Maiden Surname)

MARCELLA V. WINTERS

19a. Informant's Name/Relationship (Type, Print)

DAWN WOLFE (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

504 EAST LYNN AVENUE - BALTIMORE, MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

11/19/96

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

M. Neal Coleman

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE - BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest Secondary to Electro Mechanical
Dissociation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End Stage Renal Disease
Due to (or as a consequence of):

3 months

c. Coronary Artery Disease
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Infected Quintron Catheter

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

May T. Schen

29c. License number

D38747

29d. Date signed (Month, Day, Year)

11/15/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

716 Maiden Choice Lane

Catonsville

MD

21228

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

96 34646

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LILLIAN O. SCHANINGER | | | | 2. DATE OF DEATH
MONTH 11 DAY 15 YEAR 1996 | | 3. TIME OF DEATH
12:10 A. M. | |
| 4. SOCIAL SECURITY NUMBER
216-03-6495 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 17, 1904 | |
| 9a. FACILITY NAME (If not institution, give street and number)
The Wesley Home-2211 W. Rogers Ave. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
Baltimore City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore City | | 10c. CITY, TOWN OR LOCATION
Baltimore City | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2211 W. Rogers Avenue | | | | 10f. ZIP CODE
21209 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
In Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Edward P. Schaninger | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillie N. Brown | | | |
| 19a. INFORMANT'S NAME (Type/Print)
The Wesley Home | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2211 W. Rogers Avenue Baltimore, Maryland 21209 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Parkwood Cemetery | | DATE
11/18 | | 20c. LOCATION — City or Town, State
Parkville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James Henss Carpenter</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Burgee-Henss Funeral Home
3631 Falls Road Baltimore, Maryland 21211 | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CONGESTIVE HEART FAILURE | | | | Approximate interval Between Onset and Death
DAYS | |
| | | b. CONGESTIVE CARDIOMYOPATHY | | | | YEARS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | YEARS | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| ESSENTIAL HYPERTENSION, DIABETES MELLITUS, | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Robert E. Rohy Jr. M.D.</i> | | | | | |
| | | 29c. LICENSE NUMBER
D-19425 | | 29d. DATE SIGNED (Month, Day, Year)
11/15/96 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
2211 W. ROGERS AVENUE BALTIMORE, MD. 21209 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 10 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34647

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alyce Caroline Schmeidel

2. Date of Death
Month Day Year

November 16, 1996

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

3 Briarfield Ct.

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

5. Social Security Number

060-07-7084

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 15, 1915

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Briarfield Ct.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown

Christsen

18. Mother's Name (First, Middle, Maiden Surname)

Rina

Unknown

19a. Informant's Name/Relationship (Type, Print)

John C. Schmeidel/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Briarfield Ct. Lutherville, Md. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Cemetery

Date

11-19-96

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

Kenneth J. Paughy

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dilated Cardiomyopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John C. Schmeidel, M.D.

29c. License number

D30948

29d. Date signed (Month, Day, Year)

11/16/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OBMC

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John C. Schmeidel

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34648

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Virginia Sands | | | | 2. Date of Death
Month Day Year
November 16, 1996 | | 3. Time of Death
5:00 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
4204 Antique Lane | | | | 4b. City, Town, or Location of Death
Glenarm | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
215-14-4330 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
7-18-1922 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Glenarm | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
4204 Antique Lane | | | | 10f. Zip Code
21057 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
American Totalizator | | | | |
| | 17. Father's Name (First, Middle, Last)
Adam H. McQuay | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Minna Wagner | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Charles E. Sands (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4204 Antique Lane, Glenarm, Maryland 21057 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Long Green | | Date
11-19-96 | | 20c. Location - City or Town, State
Hydes, Maryland | | |
| | 21. Signature of Funeral Service Licensee
Wallace S. Brooks, Jr. | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Road, Towson, Md. 21204 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| | <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <u>Colon Cancer</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div> <p>Approximate Interval Between Onset and Death
14 months</p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Paul Celano, M.D. | | | | 29c. License number
D30929 | | 29d. Date signed (Month, Day, Year)
11/17/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Paul Celano, M.D. 6569 N. Charles Street, Towson, Md. 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
[Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34649

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hayward

Strother

2. Date of Death

November 13, 1996

3. Time of Death

9:55 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

231-05-0584

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth (Month, Day, Year)

04/28/1915

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3110 Presbury Street

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collegiate (1-4 or 5+)

1+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Educational

17. Father's Name (First, Middle, Last)

David Strother

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Chapman

19a. Informant's Name/Relationship (Type, Print)

Mrs. Ellen Strother-Pitts daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3110 Presbury Street Baltimore, Md. 21216

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

11/18/96 Baltimore County, Md.

21. Signature of Funeral Service Licensee

H. E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 weeks

b.

Aspiration

Due to (or as a consequence of):

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicidal ☐ Homicidal

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Song MD

29c. License number

AS 2402321-DS-9034

29d. Date signed (Month, Day, Year)

Nov. 13, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Danny Song MD

Sinai Hospital

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

J. Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the certifier or attending physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



NOV 19 1961

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34650

| | | | | | | | | |
|-------------------------------------|--|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARIETTA SCALLY | | | | 2. Date of Death
Month 11 Day 16 Year 96 | | 3. Time of Death
1225 PM | |
| | 4a. Facility Name (If not Institution, give street and number)
Bayview Geriatric Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-01-2259 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
3/19/1918 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
6001 Eastern Parkway | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Copy Writer | | 16b. Kind of Business/Industry
PHH Inc. | | | |
| | 17. Father's Name (First, Middle, Last)
William Ernest Anderson | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Gorman | | 19a. Informant's Name/Relationship (Type, Print)
Michael Scally | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6802 Everall Avenue Baltimore, Maryland 21206 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland | | 20d. Date
11/20/96 | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
The Dippel Funeral Home Inc.
7110 Belair Road Baltimore, Maryland 21206 | | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
1. COPD EXACERBATION
Due to (or as a consequence of):
2. LEGIONELLA PNEUMONIA
Due to (or as a consequence of):
3. ISCHEMIC CARDIOMYOPATHY
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
24 HOURS
4 MONTHS | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ISCHEMIC CARDIOMYOPATHY | | 23c. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28. Date of Injury (Month, Day, Year)
11/20/96 | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D46360 | | 29d. Date signed (Month, Day, Year)
11-17-96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL A. ANJUM 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD | | 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#4C FILM#G&41 PER PHYSCN 11-19-96 J.A. Certificate of Death

Reg. No.

96 34651

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|---|--|---|--|---|---|--|----------------------------------|------------------------|----------------------------------|---|---------------------|-------------------------|----------------------------------|----------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LOUISE A. TAYLOR | | | | 2. Date of Death
Month NOVEMBER Day 14 Year 1996 | | 3. Time of Death
21:55 | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL OF BALTIMORE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
217-14-9308 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 10, 1917 | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
3836 Lyndale Avenue | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade | | College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Felix Terjung | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Kurrle | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
John W. Terjung (Nephew) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
708 218th Street, Pasadena, Maryland 21122 | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | 20c. Location - City or Town, State
11-18 Baltimore, Maryland | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Schimunek Funeral home
3331 Brehms Lane, Baltimore, Maryland 21213 | | | | | | | | | | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ADULT RESPIRATORY DISTRESS SYNDROME</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. HYPERTENSION</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. PNEUMONIA</td> <td rowspan="3">MONTHS
YEARS
DAYS</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. ADULT RESPIRATORY DISTRESS SYNDROME | Approximate Interval Between Onset and Death | Due to (or as a consequence of): | b. HYPERTENSION | Due to (or as a consequence of): | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. PNEUMONIA | MONTHS
YEARS
DAYS | Due to (or as a consequence of): | d. _____ |
| | Immediate Cause (Final disease or condition resulting in death) | a. ADULT RESPIRATORY DISTRESS SYNDROME | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| b. HYPERTENSION | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. PNEUMONIA | MONTHS
YEARS
DAYS | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | d. _____ | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
AS2402321-JW-9022 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 14, 1996 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JOHN VAN WU, M.D. 2401 W. Belvedere Ave., Baltimore, Maryland 21215 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

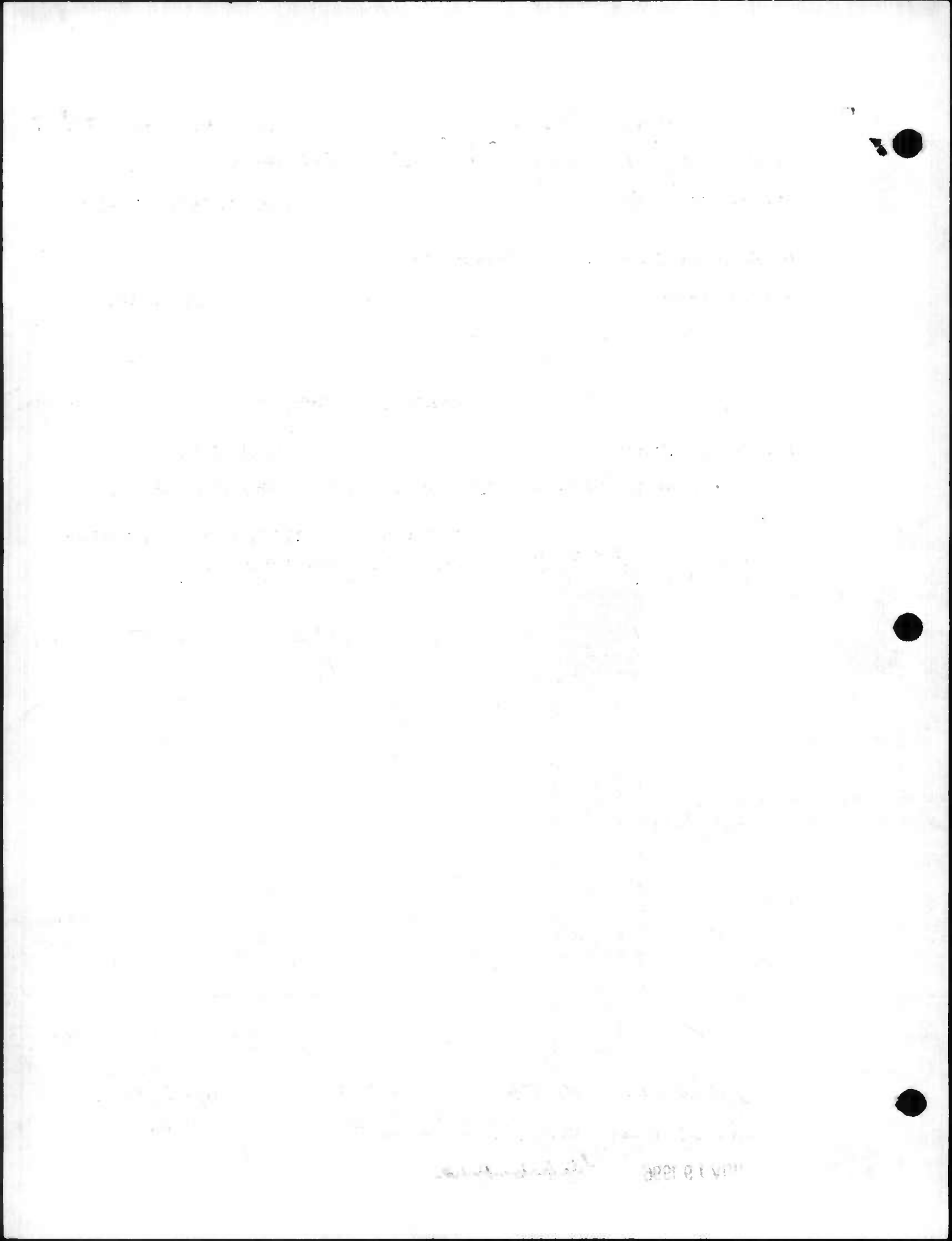
ITEM 1 per M.D G-741 11/19/96 reb State of Maryland / Department of Health and Mental Hygiene
Film G741 item 1 per PH 11-13-96 rja

Certificate of Death

Reg. No.

96 34652

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Truman, Edward Thomas Truman</u> | | | | 2. Date of Death
Month <u>11</u> Day <u>03</u> Year <u>96</u> | | 3. Time of Death
<u>4:14 pm</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>University of Maryland MS Baltimore</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>N/A</u> | |
| Funeral
Director | 5. Social Security Number
<u>218-26-3827</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>74</u> Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>Dec. 01, 1921</u> | 9. Birthplace (State or Foreign Country)
<u>Florida</u> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>Maryland</u> | | 10b. County
<u>Baltimore Co.</u> | | 10c. City, Town or Location
<u>Lutherville</u> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
<u>600 College Ave.</u> | | | | 10f. Zip Code
<u>21093</u> | | 10g. Citizen of What Country?
<u>United States</u> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>4/12/40</u>
If Yes, Give Year or Dates: <u>to 4/11/46</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>10</u> College (14 or 5+) <u></u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Air Conditioning & Refrig. Maint., Air Cond. & Refrig.</u> | | 16b. Kind of Business/Industry | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<u>Howard Parks Thomas</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Mary Louise Stanford</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>Margaret M. (nee Ludwig) Thomas (Wife)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>600 College Ave. Lutherville, Md. 21093</u> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Dulaney Valley Mem. Gard.</u> | | 20c. Location - City or Town, State
<u>11/07/96 Timonium, Maryland</u> | | | |
| | 21. Signature of Funeral Service Licensee
<u>Jeffrey L. Gair</u> | | 22. Name and Address of Facility
<u>Ruck Towson Funeral Home, Inc.</u>
<u>1050 York Road Towson, Maryland 21204</u> | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
a. <u>Cardiac and Respiratory Arrest</u> 30 min
Due to (or as a consequence of):
b. <u>Coronary Artery disease</u>
Due to (or as a consequence of):
c. <u></u>
Due to (or as a consequence of):
d. <u></u> | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
{ <u></u> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Esophageal cancer</u> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<u>Sidorov M.D.</u> | | | | 29c. License number
<u>#8594</u> | | 29d. Date signed (Month, Day, Year)
<u>11/03/96</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Mad Sidorov M.D. Department Surgery UMMS</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>NOV 19 1996</u> | | 32. Registrar's Signature
<u>Kia Davidson-Randall</u> | | | | | | |



96 34653

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Bessie Titcomb</u> | | | | 2. DATE OF DEATH
MONTH <u>November</u> DAY <u>12</u> YEAR <u>1996</u> | | 3. TIME OF DEATH
<u>06:15 A</u> M | |
| 4. SOCIAL SECURITY NUMBER
<u>008-07-5572</u> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>99</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>April 8, 1897</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Manor Care Nursing Home</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Silver Spring</u> | | 9c. COUNTY OF DEATH
<u>Montgomery</u> | |
| 10a. STATE
<u>Maryland</u> | | | | 10b. COUNTY
<u>Howard</u> | | 10c. CITY, TOWN OR LOCATION
<u>Columbia</u> | |
| 10d. INSIDE CITY LIMITS
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<u>5901 Millrace Court</u> | | | |
| 10f. ZIP CODE
<u>21045</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>White</u> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>College</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>Stitcher</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Shoe Factory</u> | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Charles Moore</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Ella A. Berry</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Forrest C. Titcomb (Son)</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>5901 Millrace Court Columbia, Maryland 21045</u> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Cedar Hill Cemetery</u> | | DATE
<u>November 15, 1996</u> | | 20c. LOCATION — City or Town, State
<u>Suitland, Maryland</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Witzke Funeral Homes, Inc.</u>
<u>5555 Twin Knolls Road Columbia, Maryland 21045</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Dementia</u> | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. <u>Constrictive heart failure</u> | | | | | | | |
| c. <u>Due to (OR AS A CONSEQUENCE OF):</u> | | | | | | | |
| d. <u>Due to (OR AS A CONSEQUENCE OF):</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M <u>1</u> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>[Signature]</u> | | | | 29c. LICENSE NUMBER
<u>043237</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>11-13-96</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>19201 Laurel PK Dr #102 Laurel MD 20707</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>NOV 19 1996</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34654

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NELLIE VIRGINA PORTER

TRADER

2. Date of Death

Nov. 9 1996

3. Time of Death

9:05 AM

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

217-07-1844

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

09-01-1906

9. Birthplace (State or Foreign Country)

OTTOMAN, VA.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WORCESTER

10c. City, Town or Location

BERLIN

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3 GRACE STREET

10f. Zip Code

21811

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Navar Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

00

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Buainess/Industry

RESIDENCE

17. Father's Name (First, Middle, Last)

LEVIN ANDREW PORTER

18. Mother's Name (First, Middle, Maiden Surname)

NELLIE MARY HATTON

19a. Informant's Name/Relationship (Type, Print)

JAMES R. TRADER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

528-B ALABAMA AVE., SALISBURY, MARYLAND 21801-5765

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BUCKINGHAM CEMETERY 11-13-1996

Date

20c. Location - City or Town, State

BERLIN, MARYLAND

21. Signature of Funeral Service Licensee

Thomas R. Trader

22. Name and Address of Facility

TRADER FUNERAL HOME INC.

12 LOTUS STREET, DOVER, DELAWARE 19901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA AND URO SEPSIS

Due to (or as a consequence of):

b. Severe Debility

Due to (or as a consequence of):

c. Stroke, Severe Kyphosis, Advanced Age

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Atkins MD

29c. License number

D-39813

29d. Date signed (Month, Day, Year)

11/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Julia Thompson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[illegible]

96 34655

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--------------------------------|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY M. TUBMAN | | | | 2. DATE OF DEATH
MONTH NOV DAY 15 YEAR 96 | | | | 3. TIME OF DEATH
7:35 P.M. | |
| 4. SOCIAL SECURITY NUMBER
210-15-2127 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
89 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
FEB. 23, 1907 | | 8. BIRTHPLACE (State or Foreign Country)
VIRGINIA | |
| 9a. FACILITY NAME (If not institution, give street and number)
ST. ELIZABETH NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | | 9c. COUNTY OF DEATH
N/A | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
BALTIMORE | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3300 BENSON AVENUE - APT-405 | | | | 10f. ZIP CODE
21227 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 4 YRS
College (1-4 or 5+) 4 YRS | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
TEACHER | | | 16b. KIND OF BUSINESS/INDUSTRY
EDUCATION | | | |
| 17. FATHER'S NAME (First, Middle, Last)
LEONARD MAJOR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
BETTY THURSTON | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) (DAUGHTER)
ELIZABETH (BETTY) PHILLIPS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
411 ROSECROFT TERRACE - BALTIMORE, MD 21229 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
NEW CATHEDRAL CEMETERY 11/19 | | DATE | | 20c. LOCATION — City or Town, State
BALTIMORE | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>M. Neal Cohen</i> | | | | 22. NAME AND ADDRESS OF FACILITY
HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pancreatic Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Conjunctive heart failure
HT
Peptic Ulcer Disease
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | Approximate Interval Between Onset and Death
4 months | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Nomicide <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>R. A. H. H. H.</i> | | | | 29c. LICENSE NUMBER
D35626 | | 29d. DATE SIGNED (Month, Day, Year)
Nov 18, 1996 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Regina A. H. H. H. 3421 Benson Ave Balt MD | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 19 1996 | | 32. REGISTRAR'S SIGNATURE
<i>Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34656

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT, H. WASKEY | | | | 2. Date of Death
Month 11 Day 14 Year 96 | | 3. Time of Death
04:30 | |
| | 4a. Facility Name (If not institution, give street and number)
Baltimore VAMC | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
569-32-9580 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 29, 1921 | |
| | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
1 Smeton Place #903 | | | | 10f. Zip Code
21204 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW-II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retail Meats | | 16b. Kind of Business/Industry
Self Employed | |
| | 17. Father's Name (First, Middle, Last)
Albert Calvin Waskey | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Mary Frick | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Betty Jane Waskey/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 Smeton Place #903 Towson, Md. 21204 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. | | 20c. Location - City or Town, State
11/15/96 Towson, Md. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Sepsis
Due to (or as a consequence of):
Metastatic Liver Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Diabetes
Hypertension | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
INT0001 | | 29d. Date signed (Month, Day, Year)
11/14/96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RICHARD CHUANG, BVAMC 10 N. GREEN STREET | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34657

| | | | | | | | | |
|--|---|--|---|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPHINE CHATARD WHITMAN | | | | 2. Date of Death
Month 11 Day 15 Year 96 | | 3. Time of Death
11:45 P. | |
| | 4a. Facility Name (If not institution, give street and number)
PICKERSGILL RETIREMENT COMM. | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
220-50-1051 | | 6. Sex
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
05-09-1919 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD. | | 10b. County
BALTIMORE | | 10c. City, Town or Location
TOWSON | |
| To Be Completed by
Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
615 CHESTNUT AVENUE | | | | 10f. Zip Code
21204 | | 10g. Citizen of What Country?
U.S.A. | |
| To Be Completed by
Physician/Medical Examiner | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 YEARS | | Collage (1-4 or 5+) Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE | | 16b. Kind of Business/Industry
OWN HOME | |
| To Be Completed by
Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
WILLIAM MILES CHATARD | | | | 18. Mother's Name (First, Middle, Maiden Surname)
JOSEPHINE LEE | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
WILLIAM C. WHITMAN (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
313 EAST LANE, BALTIMORE, MARYLAND, 21210 | | | |
| To Be Completed by
Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL CEM. | | 20c. Location - City or Town, State
11-19-96 BALTO., MD., 21229 | |
| | 21. Signature of Funeral Service Licensee
R. H. R... | | | | 22. Name and Address of Facility
HENRY W. JENKINS AND SONS COMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | |
| To Be Completed by
Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Acute cerebral infarction | | | | | | | Approximate Interval Between Onset and Death
4 days |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year)
NA | | 28b. Time of injury
M | | 28c. Injury et Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by
Physician/Medical Examiner | 28d. Describe how injury occurred | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | 29b. Signature and title of certifier
R. H. R... | | | | 29c. License number
D25205 | | 29d. Date signed (Month, Day, Year)
11-16-1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. ANTHONY RILEY M.D., 6701 NORTH CHARLES ST., TOWSON, MARYLAND, 21204 | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | 31. Date (Month, Day, Year)
NOV 19 1996 | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | |
| | | | | | | | | |

1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column. The names are mostly male, and the dates range from the 18th to the 19th century.

2. The second part of the document is a series of paragraphs of text, also written in cursive. The text is somewhat difficult to read due to the handwriting, but it appears to be a narrative or a report of some kind. The paragraphs are separated by small gaps, and the text is written in a single column.

3. The third part of the document is a list of names and dates, similar to the first part. This list is also organized into columns, with names in the first column and dates in the second column. The names are mostly male, and the dates range from the 18th to the 19th century.

4. The fourth part of the document is a series of paragraphs of text, similar to the second part. The text is written in cursive and is somewhat difficult to read. The paragraphs are separated by small gaps, and the text is written in a single column.

5. The fifth part of the document is a list of names and dates, similar to the first and third parts. This list is also organized into columns, with names in the first column and dates in the second column. The names are mostly male, and the dates range from the 18th to the 19th century.

6. The sixth part of the document is a series of paragraphs of text, similar to the second and fourth parts. The text is written in cursive and is somewhat difficult to read. The paragraphs are separated by small gaps, and the text is written in a single column.

7. The seventh part of the document is a list of names and dates, similar to the first, third, and fifth parts. This list is also organized into columns, with names in the first column and dates in the second column. The names are mostly male, and the dates range from the 18th to the 19th century.

8. The eighth part of the document is a series of paragraphs of text, similar to the second, fourth, and sixth parts. The text is written in cursive and is somewhat difficult to read. The paragraphs are separated by small gaps, and the text is written in a single column.

9. The ninth part of the document is a list of names and dates, similar to the first, third, fifth, and seventh parts. This list is also organized into columns, with names in the first column and dates in the second column. The names are mostly male, and the dates range from the 18th to the 19th century.

10. The tenth part of the document is a series of paragraphs of text, similar to the second, fourth, sixth, and eighth parts. The text is written in cursive and is somewhat difficult to read. The paragraphs are separated by small gaps, and the text is written in a single column.

AL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34658

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROSA B WITHERSPOON | | | | 2. Date of Death
Month Day Year
NOVEMBER 17 1996 | | 3. Time of Death
8:16 PM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-20-2319 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
January 21, 1923 | 9. Birthplace (State or Foreign Country)
South Carolina |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
608 Cargil Avenue | | | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nursing Assistant | | 16b. Kind of Business/Industry
City Hospital | | |
| 17. Father's Name (First, Middle, Last)
Tom Brunson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Benjamin | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Diana C. Bush (Granddaughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8613 Fallsrun Road Ellicott City, Maryland 21043 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestlawn Memorial Park | | 20c. Date
November 22, 1996 | | 20d. Location - City or Town, State
Marriottsville, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc
1630 Edmondson Avenue Catonsville, Maryland 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>atherosclerotic Cardiovascular disease</i>
Due to (or as a consequence of):
b. <i>hypertension and diabetes mellitus</i>
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____

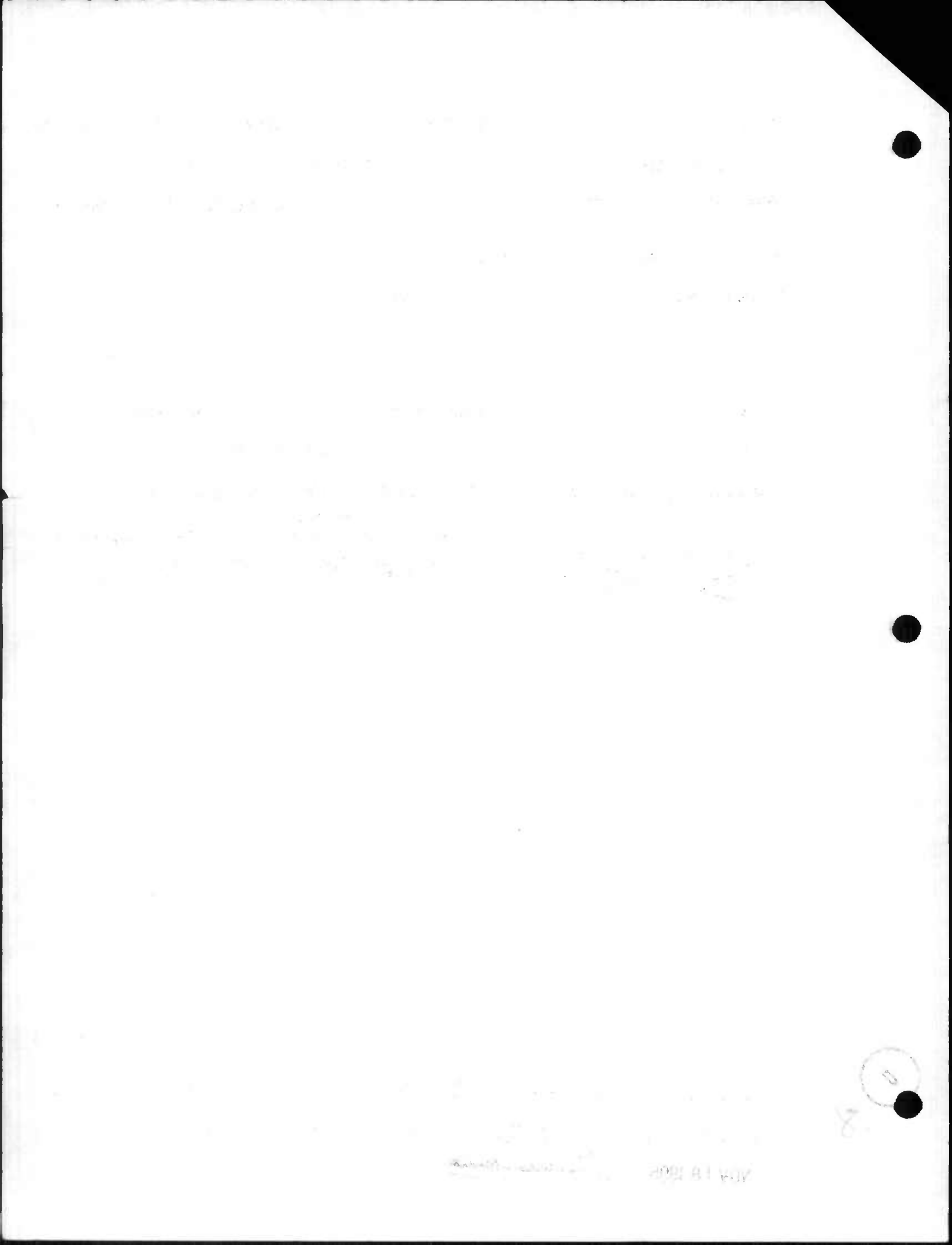
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature]</i>
Prudence J. Jackson, MD | | 29c. License number
D-37659 | | 29d. Date signed (Month, Day, Year)
November 17, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
900 Caton Avenue, Baltimore Maryland 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34659

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LAURA

WERBLOW

2. Date of Death

Month

Day

Year

November Sixteen 96 07 00 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6034 WILD GINGER COURT

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

087-03-8185

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

5-29-1915

9. Birthplace (State or Foreign Country)

New York U.S.A.

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6034 WILD GINGER COURT

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BOOKKEEPER

16b. Kind of Business/Industry

WHOLESALE PRODUCT MKT

17. Father's Name (First, Middle, Last)

MEYER GOLDBERG

18. Mother's Name (First, Middle, Maiden Summa)

SOPHIE FISHMAN

19a. Informant's Name/Relationship (Type, Print)

DEBORAH WADLE (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1117 MAPLETON AVENUE BOULDER COLORADO 80304

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH MOSES FARMING DALE N.Y.

Date

NOV. 18, 1996

20c. Location - City or Town, State

FARMING DALE, N.Y.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.

5555 TWIN KNOLLS ROAD COLUMBIA MD 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. RESPIRATORY ARREST

Due to (or as a consequence of):

b. CARCINOMA LUNG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DAVID LECHTZING M.D.

29c. License number

D29888 November Sixteen 96

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID LECHTZING 2 KNOLL N. COLUMBIA MD 21045

31. Date filed (Month, Day, Year)

NOV 19 1996

State
Registrar

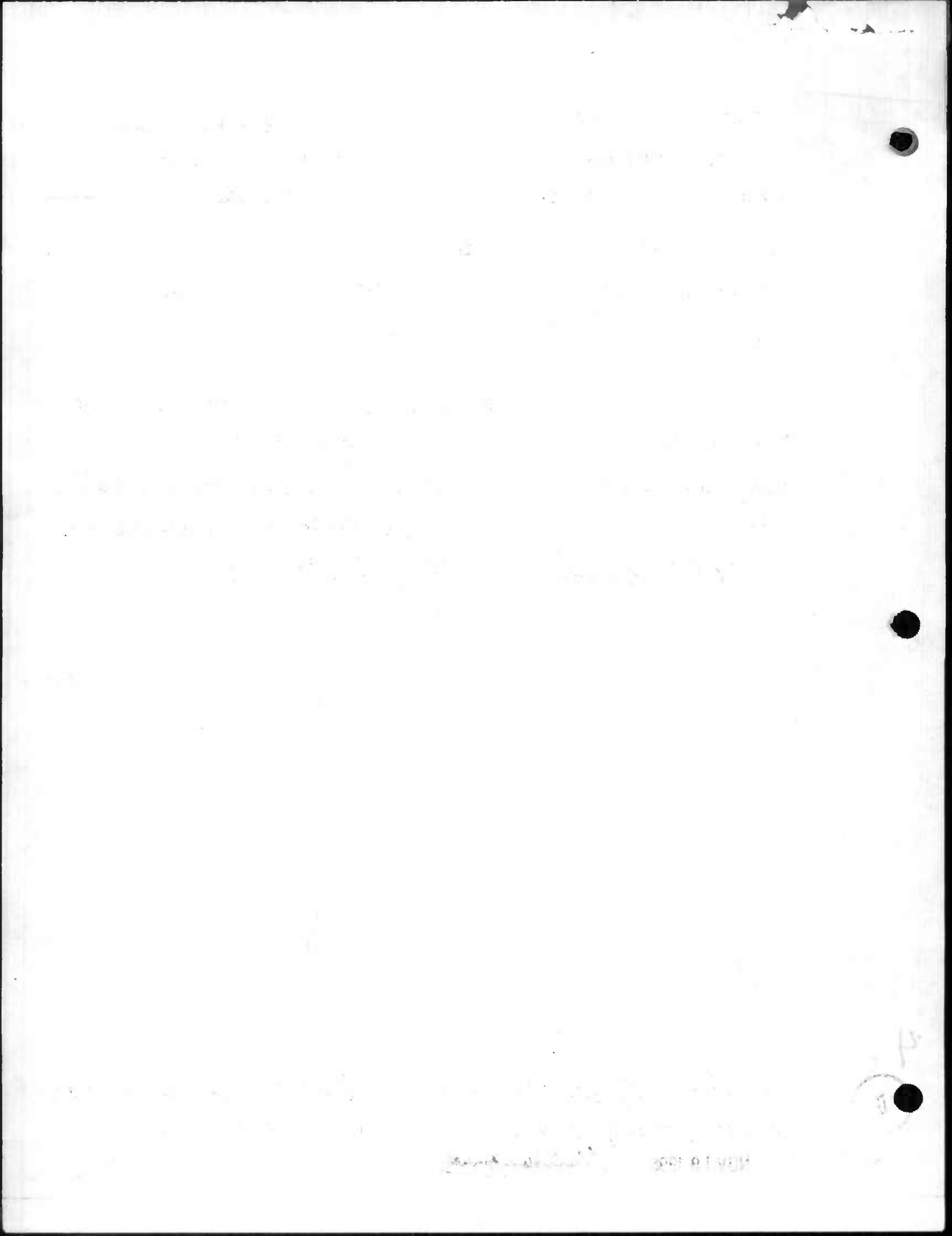
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 900-686-9000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34660

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Wilbur Wade Wolf | | | | 2. Date of Death
Month Day Year
November 14 1996 | | 3. Time of Death
2:00 a.m. | |
| | 4a. Facility Name (If not Institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-01-8024A | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 29 1911 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Sparks | |
| Usual Residence of Decedent | | | | | | | | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 10e. Street and Number
803 Upper Glencoe Rd. | | | | | | | | |
| 10f. Zip Code
21152 | | | | | | | | |
| 10g. Citizen of What Country?
USA | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | | | | | |
| 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No '41-'46
If Yes, Give Year or Dates: WW II | | | | | | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Lawyer | | | | | | | | |
| 16b. Kind of Business/Industry
Law | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Wilbur Martin Wolf | | | | | | | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Eleanor Frederick Wolf | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ethel M. Wolf/Wife | | | | | | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
803 Upper Glencoe Rd., Sparks, MD 21152 | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial Gardens | | | | | | | | |
| 20c. Location - City or Town, State
Timonium, MD 21093 | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Victor Lengrand, Jr. | | | | | | | | |
| 22. Name and Address of Facility
Lemmon Funeral Home
10 W. Padonia Rd., Timonium, MD 21093 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Cerebrovascular Accident
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Approximate Interval Between Onset and Death
Hx Hx | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospice: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
E. Nakhuda MD
29c. License number
D15504
29d. Date signed (Month, Day, Year)
11-14-96 | | | | | | | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Towson, MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996
32. Registrar's Signature
Eddie Nakhuda | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#31 FILM#g741 11/19/96 J.A.

Certificate of Death

Reg. No.

96 34661

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PETER

WOJCICK

2. Date of Death

Month Day Year
Nov 15 1996

3. Time of Death

1-25am

4a. Facility Name (If not institution, give street and number)

Church Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

226423011

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Dec. 17, 1933

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1700 Park Drive

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Korean13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 Years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Longshoremen

16b. Kind of Business/Industry

Import & Export

17. Father's Name (First, Middle, Last)

Not Known

18. Mother's Name (First, Middle, Maiden Surname)

Helen Bochenek

19a. Informant's Name/Relationship (Type, Print)

Mrs. Bessie M. Wojcik/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1700 Park Drive Dundalk, Maryland 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hilltop Service Corp. 11/18/1996 Towson, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 2122223a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
check, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. HEPATO RENAL FAILURE

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CARCINOMA OF COLON WITH LIVER

Due to (or as a consequence of):

METASTASIS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D16402

29d. Date signed (Month, Day, Year)

Nov 15 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Y.K. SHETTY MD 100 N Broadway, BALT, MD 21231

State
Registrar

31. Date filed (Month, Day, Year)

11/15/96

32. Registrar's Signature

NOV 19 1996

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34662

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia Jarvis Woods

2. Date of Death
Month Day Year

November 17 1996

3. Time of Death
10:30 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

172-24-3674

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

June 28 1921

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits
1 ☒ Yes 2 ☐ No

10e. Street and Number

3246 TIOGA PARKWAY

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Garment Worker

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Allen Jarvis

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Sutherland

19a. Informant's Name/Relationship (Type, Print)

Deibre Schley/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3765 S.W. HULSKA STREET, PORT ST. LUCY, FLORIDA 34953

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

US BEVERLY NATIONAL

Date

11-22

20c. Location - City or Town, State

BEVERLY, NEW JERSEY

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H
1206 W. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Colo-vesicle fistula

Due to (or as a consequence of):

1 month

c. Radiation Therapy

Due to (or as a consequence of):

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Multiple Myeloma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kristen L. Fernandez

29c. License number

P10877

29d. Date signed (Month, Day, Year)

November 17, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kristen L. Fernandez 900 Caton Ave Baltimore MD 21229

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34663

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Anna YOAKUM

2. Date of Death

November 14, 1996

3. Time of Death

4:00 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

212-22-2913

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 29, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7526 Durwood Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hairdresser

16b. Kind of Business/Industry

Cosmetology

17. Father's Name (First, Middle, Last)

John Bish

18. Mother's Name (First, Middle, Maiden Surname)

Anna Ulaluk

19a. Informant's Name/Relationship (Type, Print)

Mr. Lloyd D. Yoakum, Sr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7526 Durwood Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Ht. of Jesus Cem. 11/16/96 Dundalk, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHF

Due to (or as a consequence of):

b. Diabetes

Due to (or as a consequence of):

c. COPD

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45472

29d. Date signed (Month, Day, Year)

11-15-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad Rahnama M.D. 19 Fontana Lane Suite# 102 Rossville, MD 21237

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

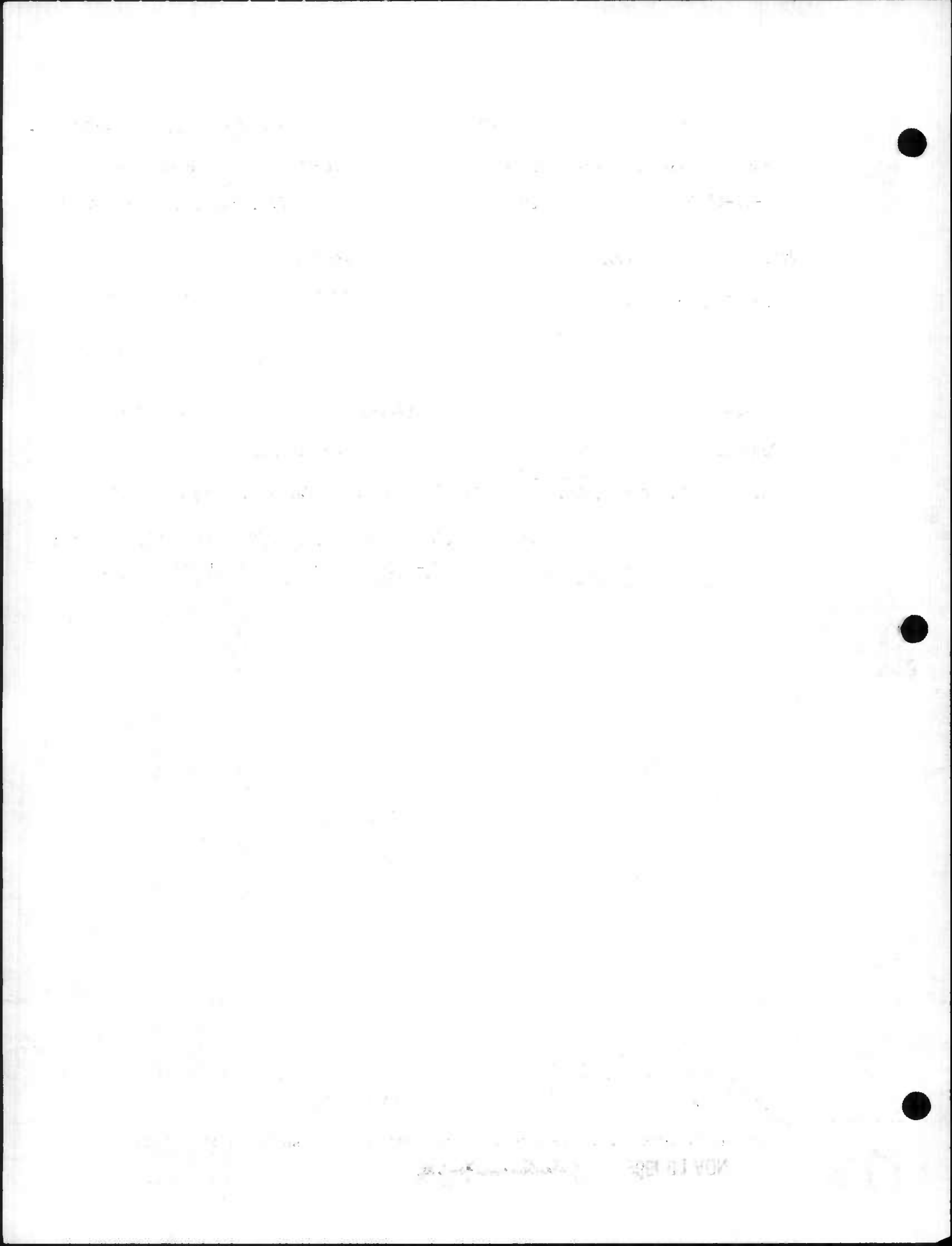
Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed to the Hospital or Attending Physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34664

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ARTHUR YARBRO

2. Date of Death

Month
11Day
13Year
1996

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

3600 GARRISON BLVD.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTO. CITY

Funeral
Director

5. Social Security Number

215-30-5163

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11-30-1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTO. CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3600 GARRISON BLVD.

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 1954-1962

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFR. AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GOV'T EMPLOYEE

16b. Kind of Business/Industry

POST OFFICE

17. Father's Name (First, Middle, Last)

JAMES A. YARBRO

18. Mother's Name (First, Middle, Maiden Surname)

ESSIE M. YARBRO

19a. Informant's Name/Relationship (Type, Print)

JAMES A. YARBRO (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2427 ARUNAH AVE. BALTIMORE MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTO. NATL. CEM.

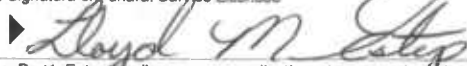
Date

11-19-1996

20c. Location - City or Town, State

BALTIMORE MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTO. MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

042178

29d. Date signed (Month, Day, Year)

11/18/96

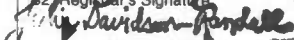
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil S. Friedman MD 4000 Old Court Rd. Ste. 300 Balto. MD 21208

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed/mailed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: 23 PART I, per M.D. G-741 11/19/96 ^{reb} Certificate of Death

Reg. No.

96 34665

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary YORK

2. Date of Death

Month Day Year
Nov. 10 1996

3. Time of Death

5:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

830 W. 40th Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-34-1498

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 10, 1913

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

830 W. 40th Street

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Robert F. York

18. Mother's Name (First, Middle, Maiden Surname)

Nettie Holman

19a. Informant's Name/Relationship (Type, Print)

Winn Friddell / friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

805 N. Calvert St, Balto, MD 21202

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

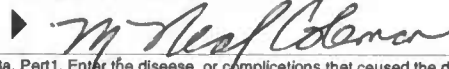
Chesapeake Crematory Inc 11/13

Date

20c. Location - City or Town, State

Beltsville MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC
4107 Wilkens Ave, Balto MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiopulmonary Arrest

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

A S C V D

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic GI bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D37145

29d. Date signed (Month, Day, Year)

11/12/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Scott Rifkin - 21 CROSSROADS DR. OWINGS MILLS, MD.

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature

400 81 000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#1 PER PHYSICIAN FILM#G741 11-19-96J. Certificate of Death

Reg. No.

96 34666

| | | | | | | | | | | | | | | | |
|---|--|---|---|---|--|---|------------------|----------------------------------|--|----------------------------------|----------------------------------|----------|----------------------------------|----------|----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNE J. ZITO | | 2. Date of Death
Month NOVEMBER Day 14 Year 1996 | | 3. Time of Death
10:00 am | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
820-06-3931 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months 0 Days 0 | If Under 24 Hrs.
Hours 0 Min. 0 | | | | | | | | | | |
| | 8. Date of Birth (Month, Day, Year)
Feb. 9, 1917 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | | | | | | | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 10e. Street and Number
3607 Dudley Avenue | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
8th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Salvatore Serio | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anntoinette Glorioso | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
John Zito (Husband) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3607 Dudley Avenue, Baltimore, Maryland 21213 | | | | | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Mausoleum | | 20c. Location - City or Town, State
11-18 Baltimore, Maryland | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Schimunek Funeral Home
3331 Brehms Lane, Baltimore, Maryland 21213 | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Sepsis</td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death
2 weeks</td> </tr> <tr> <td>b. bilateral hip decubiti</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____</td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | Due to (or as a consequence of): | Approximate Interval Between Onset and Death
2 weeks | b. bilateral hip decubiti | Due to (or as a consequence of): | c. _____ | Due to (or as a consequence of): | d. _____ | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | Due to (or as a consequence of): | Approximate Interval Between Onset and Death
2 weeks | | | | | | | | | | | | |
| | b. bilateral hip decubiti | Due to (or as a consequence of): | | | | | | | | | | | | | |
| | c. _____ | Due to (or as a consequence of): | | | | | | | | | | | | | |
| | d. _____ | Due to (or as a consequence of): | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers dementia | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | | | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D46360 | | 29d. Date signed (Month, Day, Year)
11-14-96 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 19 1996 | | 32. Registrar's Signature
 | | | | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34667

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EUGENE D

2. Date of Death
Month Day Year

OCT. 31, 1996

3. Time of Death

2:40 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

508 01 7291

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 15, 1917

9. Birthplace (State or Foreign Country)

South Dakota

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

16010 Excalibur Rd.

10f. Zip Code

20716

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Summa)

Unavailable

19a. Informant's Name/Relationship (Type, Print)

Victoria W. Acers Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16010 Excalibur Rd. Bowie Maryland 20716

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 11/2/96

Data

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Malignant Ventricular Arrhythmias

Approximate Interval Between Onset and Death

DAYS

Due to (or as a consequence of):

b. Coronary Heart Disease

YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status post myocardial infarction

Status post coronary bypass

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas Miller

29c. License number

D36207

29d. Date signed (Month, Day, Year)

NOV. 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. THOMAS MILITANO 7610 CARROLL AVE. TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34668

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHIRLEY ATWELL

2. Date of Death

Month Day Year
OCTOBER 29, 1996

3. Time of Death

10:09PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-52-7272

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/14/1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3806 Rush Road

10f. Zip Code

21084

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Caucasian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Computer Technician

18b. Kind of Business/Industry

Bell Atlantic
Telephone

17. Father's Name (First, Middle, Last)

George

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Elizabeth Ellis

19a. Informant's Name/Relationship (Type, Print)

A. Elaine Atwell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10026 Hillgreen Circle Cockeysville, Md. 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bel Air Mem. Gardens 11/2 Bel Air, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M. Blackden Kurtz

22. Name and Address of Facility

Kurtz Funeral Home, P.A.
Jarrettsville, Maryland23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

RESPIRATORY FAILURE

Due to (or as a consequence of):

PNEUMONIA

Due to (or as a consequence of):

IMMUNE DEFICIENCY

Due to (or as a consequence of):

CHRONIC STEROID USE FOR CHRONIC OBSTRUCTIVE
LUNG DISEASEApproximate
Interval Between
Onset and Death

6 days

2 months

2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HODGKINS LYMPHOMA treated with

CHEMOTHERAPY + RADIATION therapy

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Walter Hepner

29c. License number

D23450

29d. Date signed (Month, Day, Year)

10/30/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter Hepner

Jacksonville, Maryland

31. Date filed (Month, Day, Year)

NOV 1 1996

32. Registrar's Signature

John Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1-1-1947

1-1-1947

unclassified

unclassified

1-1-1947

1-1-1947

1-1-1947

1-1-1947

1-1-1947

1-1-1947

1-1-1947

1-1-1947

1-1-1947

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1-1-1947

1-1-1947

5+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34669

| | | | | | | | | | |
|--|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George Kenneth Amos | | | | 2. Date of Death
Month 11 Day 1 Year 96 | | 3. Time of Death
03:26am | | |
| | 4a. Facility Name (If not Institution, give street and number)
Baltimore Veterans Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
212-30-1144 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
1/17/1931 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
607 S. Port Street | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Material hauling | | | | |
| | 17. Father's Name (First, Middle, Last)
Benjamin Amos | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lulu Williams | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Timothy Mark Amos/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2937 Whiteford Road Whiteford, MD 21160 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Slate Ridge Cemetery | | Data
11/5 | | 20c. Location - City or Town, State
Delta, PA | | |
| | 21. Signature of Funeral Service Licensee
<i>Jeffrey P. Lovelidge</i> | | | | 22. Name and Address of Facility
Harkins Funeral Home, Inc., Delta, PA | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Sepsis Syndrome 2 weeks
Due to (or as a consequence of):
b. Renal Failure 2 months
Due to (or as a consequence of):
c. Respiratory Failure 3 weeks
Due to (or as a consequence of):
d. Fungemia 1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
A. Rodriguez MD | | | | 29c. License number
1710163 | | 29d. Date signed (Month, Day, Year)
11/1/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alejandro Rodriguez University of Maryland Medical Systems | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 4 1996 | | 32. Registrar's Signature
<i>John A. ...</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

THE ... OF ...
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34670

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna L. Adams

2. Date of Death

Month
11Day
08Year
1996

3. Time of Death

1730pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

217-28-3990

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/04/32

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5255 Bethlehem-Harmony Road

10f. Zip Code

21655

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

18b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jessie Mitchell

18. Mother's Name (First, Middle, Maiden Surname)

Rachel Carter

19a. Informant's Name/Relationship (Type, Print)

Joyce Moaney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 463, Preston, MD 21655

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Richardson Cemetery 11/14

Date

20c. Location - City or Town, State

Easton, Maryland

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home
PO Box 43, Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardio-Respiratory Arrest

Due to (or as a consequence of):

b. GI Haemorrhage

Due to (or as a consequence of):

c. COPD, IDDM

Due to (or as a consequence of):

d. CAD

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD, IDDM, CAD.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shirin Mohammad, MD

29c. License number

D0050799

29d. Date signed (Month, Day, Year)

11-09-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Shirin Mohammad, M.D., 302 Collins Ave., Henlock, MD 21643

31. Date filed (Month, Day, Year)

NOV 13 '96

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

96 34671

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34672

Amended #17, 11/12/96

NOB, Allegany County

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARA L. ABE

2. Date of Death

November 8 1996

3. Time of Death

7:28 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

220-10-2539

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Oct 22, 1910

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

252 E. Elder Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lorenzo D. Lashley

18. Mother's Name (First, Middle, Maiden Surname)

Amy Catherine (Schriver)

19a. Informant's Name/Relationship (Type, Print)

James Stevenson-nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Cresaptown, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Memorial Park

Date

11/14

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPTIC SHOCK

Approximate Interval Between Onset and Death

3 DAYS

Due to (or as a consequence of):

ISCHEMIC BOWELS

3 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sunil Gupta

29c. License number

D 33280

29d. Date signed (Month, Day, Year)

November 9, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sunil Gupta M.D. Johnson Heights Medical Bldg. Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 12 1996

32. Registrar's Signature

John J. Henshaw

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34673

| | | | | | | | | | | | | | | | |
|--|--|--|---|--------------------------|--|---|---|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joyce C. Appel | | | | 2. Date of Death
Month: Nov, Day: 2, Year: 1996 | | | | 3. Time of Death
10:56 pm | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
646 Washington Street | | | | 4b. City, Town, or Location of Death
Cumberland | | | | 4c. County of Death
Allegany | | | | | | |
| Funeral
Director | 5. Social Security Number
217-30-1969 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
63 Yrs. | | 8. Date of Birth (Month, Day, Year)
Mar 19, 1933 | | 9. Birthplace (State or Foreign Country)
VA | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
646 Washington Street | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) Retired | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired | | | 16b. Kind of Business/Industry
First American Bank | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Redford J. Comer | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Fannie L. (NMN) | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lisa L. Cooper-daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1933 Calladium Place Longwood FL 32750 | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park | | Data
11/05 | | 20c. Location - City or Town, State
Cumberland, MD | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
James F. Scarpeilli | | | | 22. Name and Address of Facility
Scarpeilli Funeral Home
Cumberland, MD 21502 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. metastatic Carcinoma of the Cecum
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
4 years | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier
Guy F. Scarpeilli | | 29c. License number
D12779 | | 29d. Date signed (Month, Day, Year)
11-4-96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. W. Guy Fiscus 500 Memorial Avenue Cumberland | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 06 1996 | | | | | | | | | | 32. Registrar's Signature
John A. Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

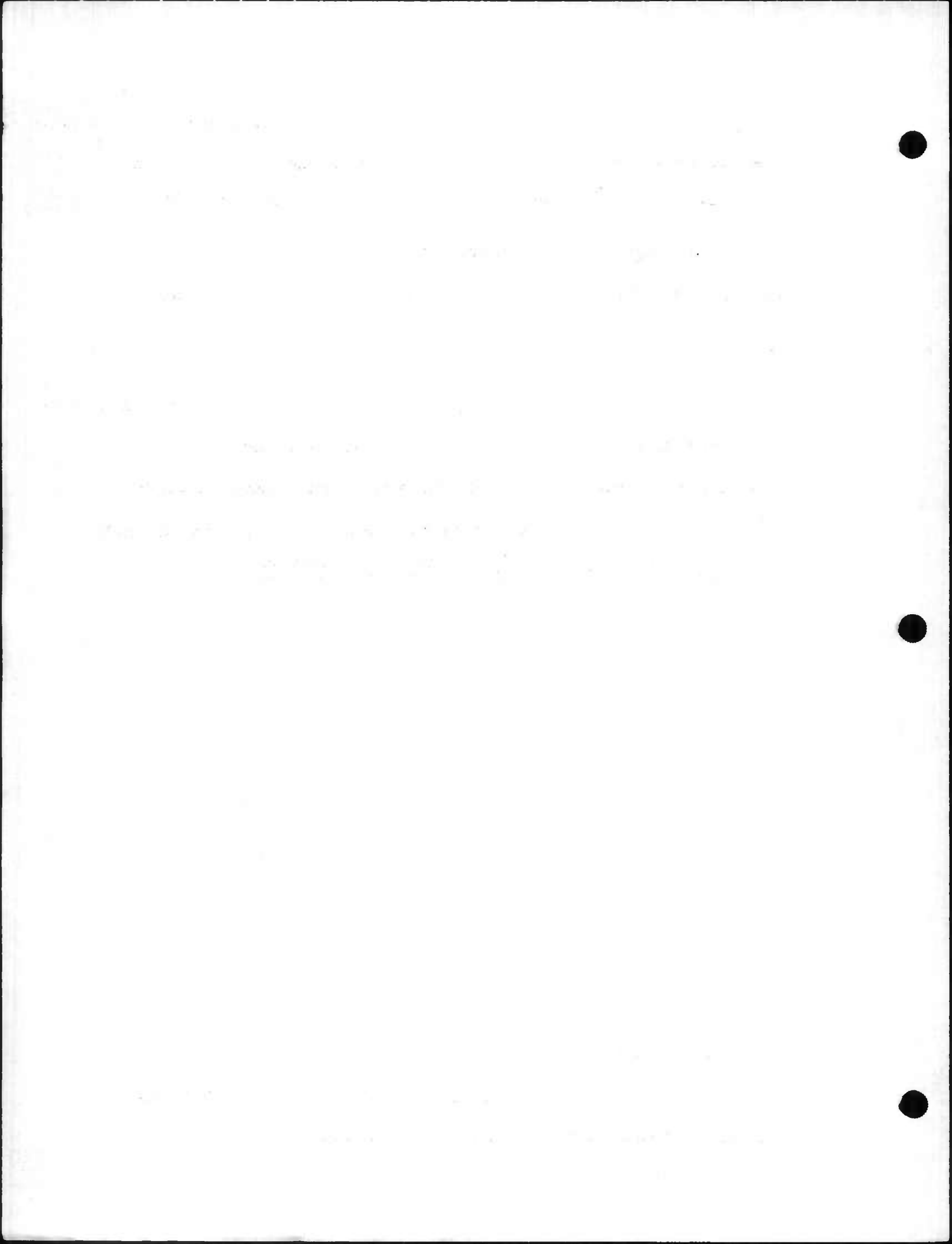
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34674

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Musa Almusawi

2. Date of Death

October 29, 1996

3. Time of Death

8:00 A.

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

549-63-3593

6. Sex

XXM 2 F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 11, 1930

9. Birthplace (State or Foreign Country)

Iraq

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 Yes 2X No

10e. Street and Number

6865 Caravan Court

10f. Zip Code

21044

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2X Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4 +4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Professor/Clergyman

16b. Kind of Business/Industry

University/Church

17. Father's Name (First, Middle, Last)

Hasan Almusawi

18. Mother's Name (First, Middle, Maiden Surname)

Aga Bibi Alhija

19a. Informant's Name/Relationship (Type, Print)

Moulok H. Alhashimi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. National Memorial Park

Date

10/30/1996

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DEHYDRATION AND HYPOTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTATIC STOMACH CANCER

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2X No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2X No

25. Was case referred to medical examiner?

1 Yes 2X No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2X No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nadu Tuakli

29c. License number

D38183

29d. Date signed (Month, Day, Year)

October 29, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Nadu Tuakli, M.D. 10814 Hickory Ridge Road Columbia, Maryland 21044

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34675

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Albert

Applebaum

2. Date of Death

November 6, 1996

3. Time of Death

8:15 AM

4a. Facility Name (If not institution, give street and number)

513 Mansfield Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

069-01-2266

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 8, 1912

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

513 Mansfield Road

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Physicist

16b. Kind of Business/Industry

Department of Navy

17. Father's Name (First, Middle, Last)

Nathan Applebaum

18. Mother's Name (First, Middle, Maiden Surname)

Frieda Friedman

19a. Informant's Name/Relationship (Type, Print)

Carol N. Litman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

513 Mansfield Road, Silver Spring, Maryland 20910

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

11-7-96 Beltsville, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic renal failure

Due to (or as a consequence of):

Approximate interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D21531

29d. Date signed (Month, Day, Year)

November 6, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

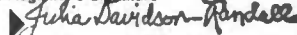
G. Peter Pushkas, M.D.

11510 Old Georgetown Road
Rockville, MD 20852

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34676

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Helen Bremer

2. Date of Death
Month Day Year

November 2, 1996

3. Time of Death

10:45 A.M.

4a. Facility Name (If not institution, give street and number)

408 August Street

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

196-20-2782

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 3, 1914

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

408 August Street

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John V. Holden

18. Mother's Name (First, Middle, Maiden Surname)

Edna Zimmer

19a. Informant's Name/Relationship (Type, Print)

Edward McKenna

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

408 August Street, Easton, Maryland 21601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Crematory

Date

11/4/96

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harrison E. Leonard Funeral Home
312 S. Talbot Street, St. Michaels, Maryland

21663

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MYELOMATOSIS
Due to (or as a consequence of):

Approximate interval Between Onset and Death

4 YRS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

J00250

29d. Date signed (Month, Day, Year)

11/3/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

C. R. W. Bain, M. D. 415 B. East Dover St., Easton, Maryland 21601

31. Date filed (Month, Day, Year)

NOV - 7 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34677

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HOMER FRANCIS BRAMBLE | | | | 2. Date of Death
Month Day Year
NOV. 2, 1996 | | 3. Time of Death
4:25 AM | |
| | 4a. Facility Name (If not institution, give street and number)
29644 CHILCUTT ROAD | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
TALBOT | |
| Funeral
Director | 5. Social Security Number
218-07-1487 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 11, 1921 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
EASTON | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
29644 CHILCUTT ROAD | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CONTRACTOR | | 16b. Kind of Business/Industry
PAINTING | | | |
| | 17. Father's Name (First, Middle, Last)
HARRY SAMUEL BRAMBLE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
RUTH ANNA MORRIS | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
BLANCHE N. BRAMBLE /WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
29644 CHILCUTT RD., EASTON, MD 21601 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SPRING HILL CEMETERY | | 20c. Location - City or Town, State
11-6 EASTON, MD | | | |
| | 21. Signature of Funeral Service Licensee
M. E. Neumann C.F.S.P. | | | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEUNAM FUNERAL HOME
200 S. HARRISON ST., EASTON, MD 21601 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. CHF
Due to (or as a consequence of):
b. VALVULAR HEART DZ
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ESRD / Chronic Hemodialysis
DM (Diabetes Mellitus) | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Ken J. O'Keefe | | | | 29c. License number
D35259 | | 29d. Date signed (Month, Day, Year)
11/4/96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ken J. O'Keefe MD 606 DUTCHMAN'S LANE EASTON MD 21601 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
NOV - 6 1996 | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

和

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34678

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|---|--|---------------------------------|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eva M. Bell | | | 2. Date of Death
Month Nov. Day 1 Year 1996 | | | 3. Time of Death
1:45P.M. | | | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | | 4b. City, Town, or Location of Death
Easton | | | 4c. County of Death
Talbot | | | |
| Funeral
Director | 5. Social Security Number
216-14-9096 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 17, 1911 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | 10a. State
Maryland | | | 10b. County
Talbot | | | 10c. City, Town or Location
Easton | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| To Be Completed by Funeral Director | 10e. Street and Number
521 Hazelwood Drive | | | 10f. Zip Code
21601 | | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) 0 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | | | 16b. Kind of Business/Industry
own home | | | |
| | 17. Father's Name (First, Middle, Last)
Thomas Mushaw | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jency Ellen Whiteley | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
John O. Bell/Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 South Fox Road, Sterling, VA., 20164 | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Springhill Cemetery 11/5 | | | Date | | 20c. Location - City or Town, State
Easton | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
JOHN R. MERCERON CFSP | | | 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
200 S. Harrison St., Easton, MD 21601 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular arrhythmia
Due to (or as a consequence of):
b. Ischemic cardiomyopathy
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | Approximate Interval Between Onset and Death
minutes
years | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
metastatic carcinoma unknown primary
end stage COPD | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
John O. Bell MD | | | | | | |
| | | | | 29c. License number
044749 | | | 29d. Date signed (Month, Day, Year)
11/1/96 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PETER L. WHITESELL, M.D., 609 DUTCHMAN'S LANE, EASTON, MD 21601 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV - 6 1996 | | | 32. Registrar's Signature
She Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very important document, as it contains the President's annual message to Congress. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

2. The second part of the document is a report from the Secretary of the Interior, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

3. The third part of the document is a report from the Secretary of the Treasury, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

4. The fourth part of the document is a report from the Secretary of the War, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

5. The fifth part of the document is a report from the Secretary of the Navy, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

6. The sixth part of the document is a report from the Secretary of the State, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

7. The seventh part of the document is a report from the Secretary of the War, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

8. The eighth part of the document is a report from the Secretary of the Navy, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

9. The ninth part of the document is a report from the Secretary of the State, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

10. The tenth part of the document is a report from the Secretary of the War, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

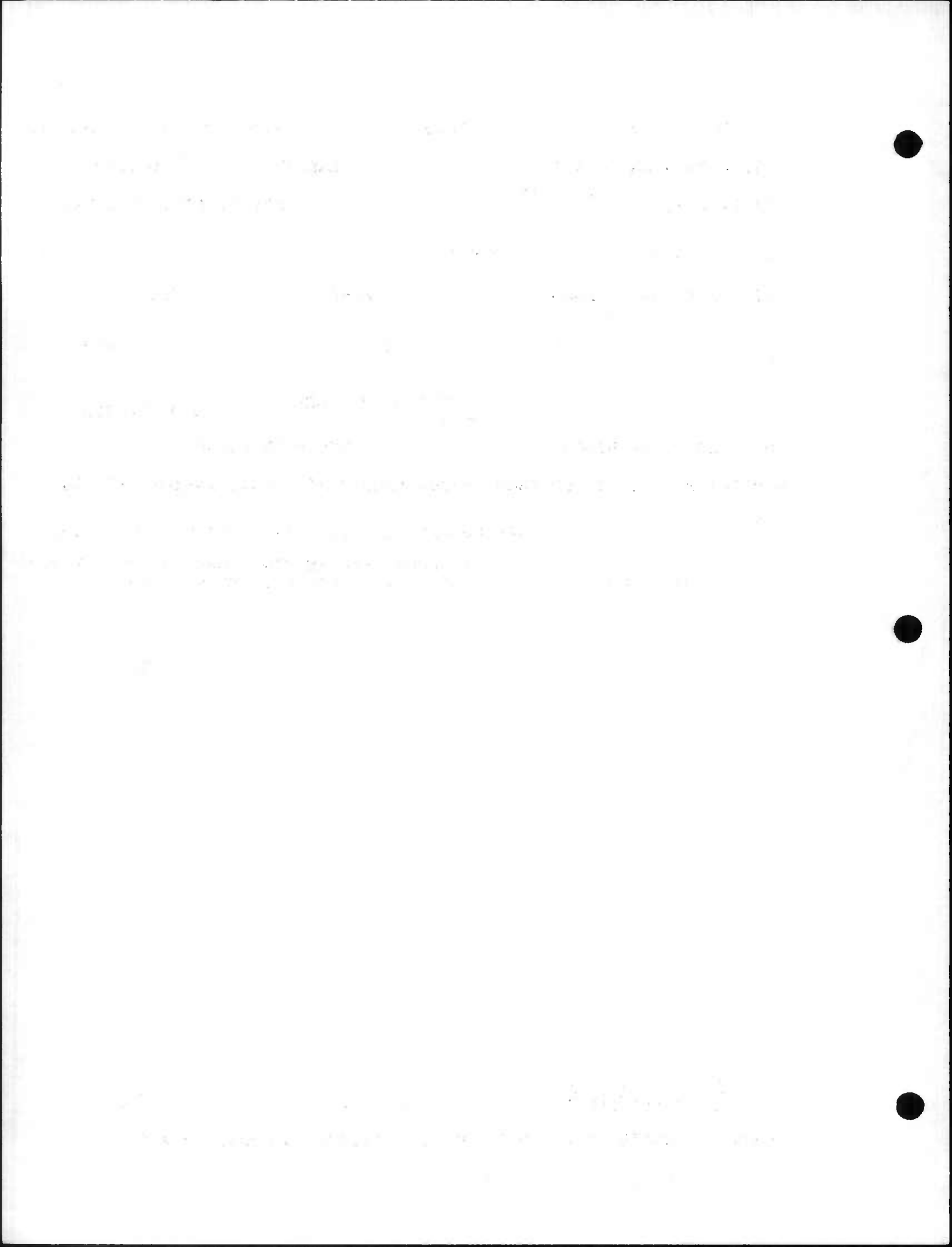
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34679

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NEVA H. BRIDGE | | | | 2. Date of Death
Month Day Year
NOV. 4 1996 | | 3. Time of Death
6:40 PM | |
| | 4a. Facility Name (If not Institution, give street and number)
8754 SWAN HAVEN ROAD | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
TALBOT | |
| Funeral
Director | 5. Social Security Number
217-14-8220 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 14, 1923 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
EASTON | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
8754 SWAN HAVEN ROAD | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TALBOT COUNTY BOARD OF EDUCATION | | 16b. Kind of Business/Industry
FOOD SERVICE | | | |
| | 17. Father's Name (First, Middle, Last)
DOUGLAS L. HARRISON | | 18. Mother's Name (First, Middle, Maiden Surname)
GERTRUDE BURROWS | | 19a. Informant's Name/Relationship (Type, Print)
DOUGLAS H. BRIDGE, SR./SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
30302 RABBIT HILL RD., EASTON, MD 21601 | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SPRING HILL CEMETERY | | 20c. Location - City or Town, State
EASTON, MD 21601 | | 20d. Date
11-7 | |
| | 21. Signature of Funeral Service Licensee
JOHN R. MERCER | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
200 S. HARRISON ST., EASTON, MD 21601 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Multiple myeloma.
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
26 mos. | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
David Smith | | 29c. License number
D39887 | | 29d. Date signed (Month, Day, Year)
11/5/96 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID H. SMITH, M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV - 6 1996 | | 32. Registrar's Signature
Julia Davidson-Randall | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34680

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GENEVA F. BROOKS

2. Date of Death

Month Day Year
Oct. 28, 1996

3. Time of Death

5:40 A.M.

4a. Facility Name (If not institution, give street and number)

PRESIDENTIAL WOODS HEALTH CARE CENTER

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-22-8220

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 10, 1921

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1801 Metzertott Road

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

African American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Sylvester Fennell

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Banks

19a. Informant's Name/Relationship (Type, Print)

Norma J. Darby - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20743
1601 Ritchie Marlboro Road, Capital Heights, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery

Date

11/6/96

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

~ 2 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicida4 ☐ Homicida6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. S. Nayar

29c. License number

D-17874

29d. Date signed (Month, Day, Year)

10-30-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. M. NAYAR, MD, 3717-38th Ave Brentwood, MD 20722

31. Date filed (Month, Day, Year)

NOV 04 1996

3. Registrar's Signature

John D. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1971

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34681

| | | | | | | | |
|--|--|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BOBBY FRANKLIN BROWN | | | 2. Date of Death
Month Day Year
OCTOBER 26, 1996 | | 3. Time of Death
1020AM | |
| | 4a. Facility Name (If not institution, give street and number)
1900 CHURCH ROAD | | | 4b. City, Town, or Location of Death
MITCHELLVILLE | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
218-84-3683 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
30 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 27, 1965 |
| | 9. Birthplace (State or Foreign Country)
Jamaica, N.Y. | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | |
| | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Mitchellville | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
775 St. Michaels Drive | | | 10f. Zip Code
20721 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
Black |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Musician/Cosmetologist Asst. | | 16b. Kind of Business/Industry
Self Employed | | |
| | 17. Father's Name (First, Middle, Last)
William Royce Brown, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Orr | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Norma Williams Brown - Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
775 St. Michaels Drive, Mitchellville, MD 20721 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee's Crematory | | Date
11/4/96 | 20c. Location - City or Town, State
Clinton, MD | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Stewart Funeral Home, Inc.
4001 Benning Road, N.E., Washington, D.C. | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. MULTIPLE GUNSHOT WOUNDS
Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) WOODS | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
FOUND 10-26-96 | | 28b. Time of Injury
UNK. M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28d. Describe how injury occurred
SUBJECT WAS SHOT | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
WOODS | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
1900 CHURCH ROAD MITCHELLVILLE, PRINCE GEORGE CO, MD | | | | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
OCTOBER 27, 1996 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34682

4 0/4

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE E. BROWN

2. Date of Death

Month
11Day
3Year
96

3. Time of Death

12:35A

4a. Facility Name (If not institution, give street and number)

HYATTSTVILLE HEALTH CARE CENTER

4b. City, Town, or Location of Death

HYATTSTVILLE

4c. County of Death

PG

Funeral
Director

5. Social Security Number

579-36-6240

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3-15-27

9. Birthplace (State or Foreign Country)

LEEBURG, VA

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1456 Oak Street, N.W.

10f. Zip Code

20010

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private Home

17. Father's Name (First, Middle, Last)

Willie Sheppard

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Thomas

19a. Informant's Name/Relationship (Type, Print)

Amelia B. Williams (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1924 Mitchellville Road, Bowie, Md. 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Nat Mem Park

Date

11/7/96

20c. Location - City or Town, State

LAUREL, MARYLAND

21. Signature of Funeral Service Licensee

Aly S. Pope Jr.

M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 Marlboro Pike, Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aids

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

8 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tom P. Kankar

29c. License number

D-20062

29d. Date signed (Month, Day, Year)

Nov 3RD, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Tom P. KANKARAT, 8201 16th St, Silver Spring Maryland 20910

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

John Davidson-Robert

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34683

Reg. No.

| | | | | | | | | |
|-------------------------------------|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALVIN BATTLE | | | | 2. Date of Death
Month Day Year
OCTOBER 31 1996 | | 3. Time of Death
1:35 AM | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
578-78-1679 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
39 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 4, 1957 | |
| | 9. Birthplace (State or Foreign Country)
Battlesboro, N.C. | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Temple Hills | |
| To Be Completed by Funeral Director | 10e. Street and Number
2326 Anvil Lane | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
United States | | 10d. Inside City Limits
1 Yes 2 No | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
African American | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Train Attendant | | 16b. Kind of Business/Industry
AMTRAK | | | |
| | 17. Father's Name (First, Middle, Last)
Albert Battle | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rose Lee Bell | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Loretta Battle Washington - Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2326 Anvil Lane, Temple Hills, MD 20748 | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | Data
11/9/96 | | 20c. Location - City or Town, State
Landover, MD | |
| | 21. Signature of Funeral Service Licensee
John T. Stewart III | | | | 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N. E., Washington, D. C. | | | |
| | 23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Lymphoma
Due to (or as a consequence of):
Acquired Immune Deficiency Syndrome
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
2 months | | | |
| | Immediate Cause (Final disease or condition resulting in death) | | | | | | | |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | |
| | | | | | | | 24e. Was an autopsy performed?
1 Yes 2 No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | |
| | 25. Was case referred to medical examiner?
1 Yes 2 No | | 28. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| | 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
[Signature] | | 29c. License number
DO9117 | | 29d. Date signed (Month, Day, Year)
10-31-96 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MELVIN D. GERALD M.D., 3001 Hospital Drive, Cheverly, MD 20785 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
NOV 05 1996 | | | | 32. Registrar's Signature
[Signature] | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

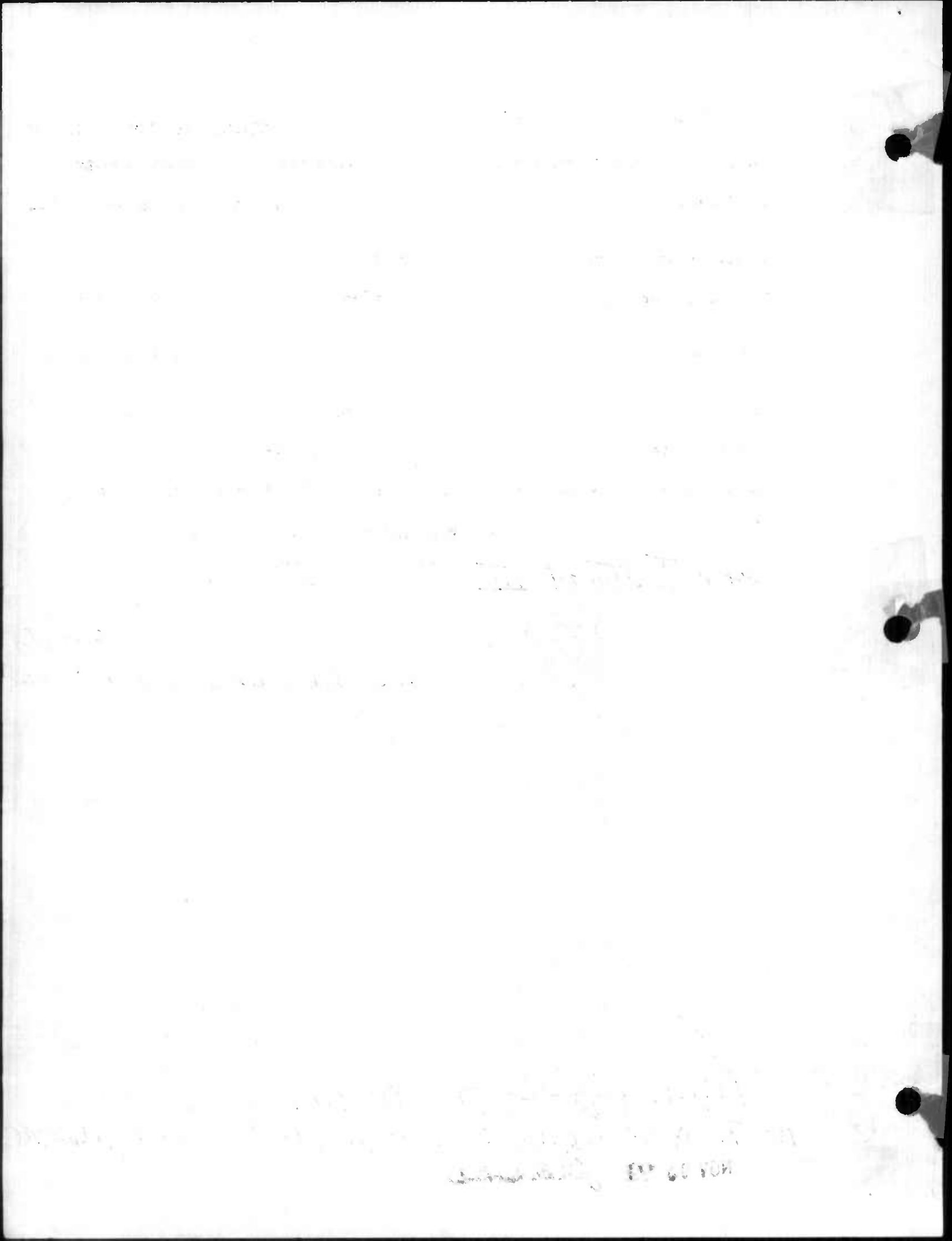
Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black, Indelible Ink. Assure All Copies Are Legible.

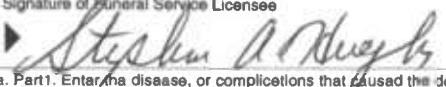
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death


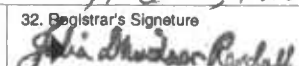
Reg. No.

96 34684

8

| | | | | | | | | |
|--|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RAYMONDE EMILIA BOOTH | | | | 2. Date of Death
Month Oct. Day 23 Year 1996 | | 3. Time of Death
10¹⁵PM | |
| | 4a. Facility Name (If not institution, give street and number)
Fallston General Hospital | | | | 4b. City, Town, or Location of Death
Fallston | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
223-42-5821 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
June 26, 1927 | 9. Birthplace (State or Foreign Country)
France |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Joppa | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
504 Echols Court | | | | 10f. Zip Code
21085 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Pierre (u/k) Feval | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Simone (u/k) (u/k) | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James E. Booth - Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
504 Echols Ct., Joppa, MD 21085 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul's Lutheran Ch. Cem. 10/28/96 Aberdeen, MD | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Md. 21009 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardio-Pulm. Causes
Due to (or as a consequence of):
b. COPD
Due to (or as a consequence of):
c. Pan. CAD
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
years.
year
year. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
None | | 28b. Time of Injury
N/A M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
N/A |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Underlying Medical Condition | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
N/A | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D23231 | | 29d. Date signed (Month, Day, Year)
10/23/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MUKESH K. TALOTA, F.G.H., FALLSTON, MD. 21047 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
10/23/96 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34685

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MCKINLEY WILLIAM BAUGUESS

2. Date of Death

November 01, 1996

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

213-18-0376

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr., 1, 1923

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Churchville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

311 West Lane

10f. Zip Code

21028

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

Hort William Bauguess

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Elizabeth Brown

19a. Informant's Name/Relationship (Type, Print)

Ronald L. Bauguess, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

311 West Lane, Churchville, Maryland 21028

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris & Co., Inc. 11/2/96 West Chester, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Probable acute myocardial infarction

5 hours

Due to (or as a consequence of):

b. Coronary artery disease

2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Korsakoff's syndrome, Anemia, Malnutrition

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

NY 151094-1

29d. Date signed (Month, Day, Year)

November 1, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MELECIA A. SANTOS, M.D., Perry Point, MD 21902

31. Date filed (Month, Day, Year)

NOV 4 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

96 34686

DMMH 16 Rev 6/95

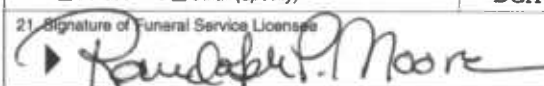
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34687

Certificate of Death

Reg. No.

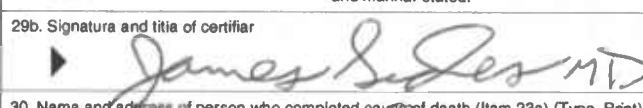
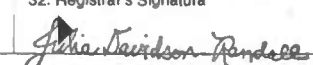
| | | | | | | | | | |
|--|---|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Genevieve Blackburn | | | | 2. Date of Death
Month 10 Day 29 Year 1996 | | 3. Time of Death
1322 | | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton, MD | | 4c. County of Death
Talbot | | |
| Funeral
Director | 5. Social Security Number
213-24-2637 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
September 24, 1928 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Denton | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
112 South Third Street | | | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
Caucasian | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 HS Grad. Collegia (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | |
| | 17. Father's Name (First, Middle, Last)
Willard Hazel Green | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lucy Helen Long | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mattie Conner Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
112 South Third Street, Denton, Maryland 21629 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Denton Cemetery | | Date
11/1/96 | | 20c. Location - City or Town, State
Denton, Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Moore Funeral Home, P.A.
PO Drawer B, Denton, Maryland 21629 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Coronary Artery Disease
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
{
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D31376 | | 29d. Date signed (Month, Day, Year)
10-31-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James Sides 920 Market St Denton MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
11/31/96 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

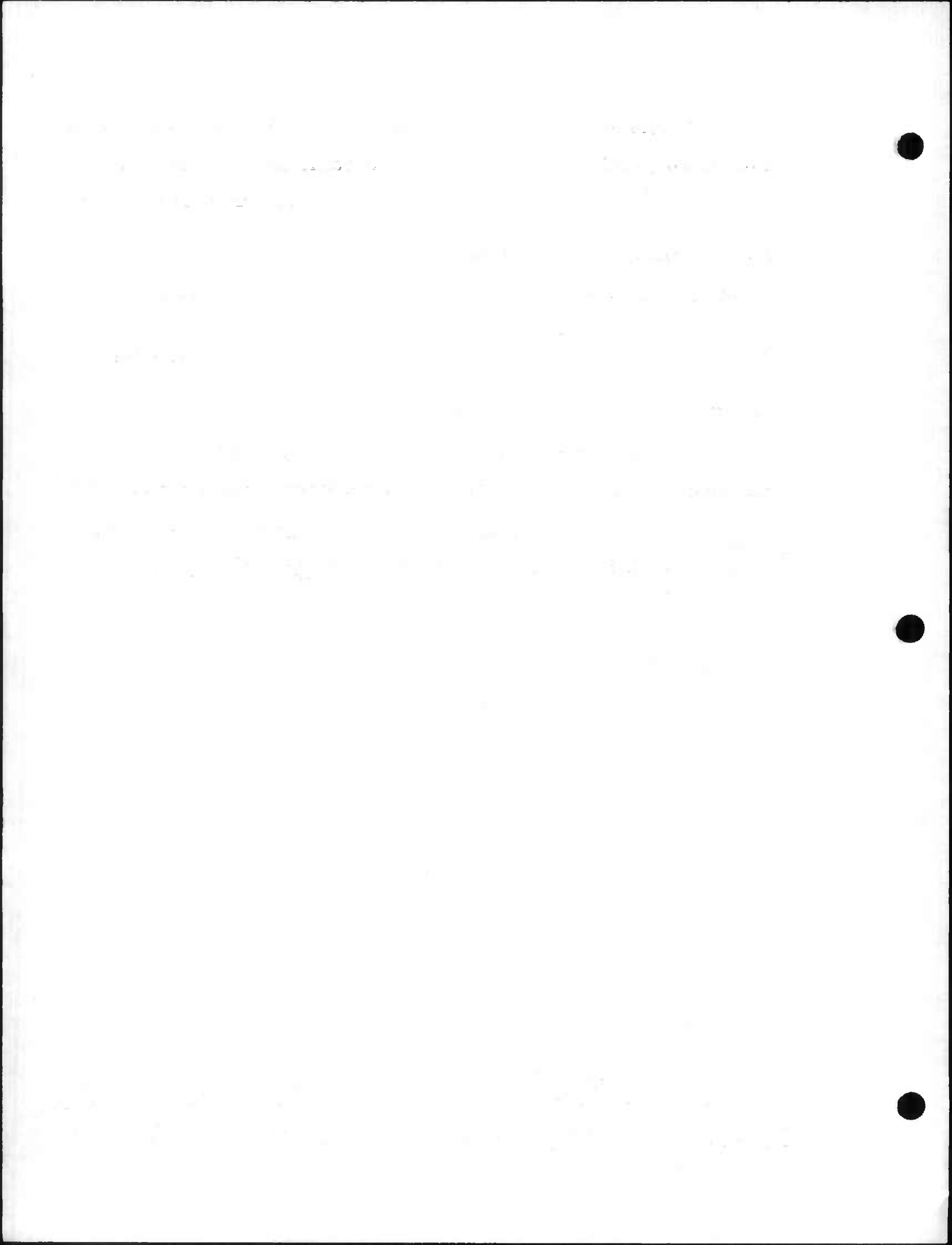
Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34688

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PEARL BEATRICE BARNES | | | 2. Date of Death
Month Day Year
NOVEMBER 7, 1996 | | 3. Time of Death
5:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
212 24 2040 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCT. 23, 1908 |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ALLEGANY | | 10c. City, Town or Location
CUMBERLAND | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
BOWMAN'S ADDITION | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
HOME | |
| 17. Father's Name (First, Middle, Last)
OSSIE HANSROTE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MAUDE RILEY | | | |
| 19a. Informant's Name/Relationship (Type, Print)
RUBY NEE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13507 NEE-WEAVER AVENUE-CRESAPTOWN, MD 21502 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ZION MEMORIAL PARK | | Date
11/9/96 | | 20c. Location - City or Town, State
CUMBERLAND, MD | |
| 21. Signature of Funeral Service Licensee
<i>George Upchurch</i> | | | | 22. Name and Address of Facility
GEORGE-UPCHURCH FUNERAL HOME, P.A.
202 GREENE ST., CUMBERLAND, MD 2102 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Arteriosclerotic Heart Disease
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
10 yrs. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Atrial Fibrillation
Chronic Congestive Heart Failure | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>John Robustiano</i> | | | | 29c. License number
D-14865 | | 29d. Date signed (Month, Day, Year)
NOV. 8, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. ROBUSTIANO J. BARRERA/MEMORIAL MEDICAL BLDG./CUMBERLAND, MD. 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 12 1996 | | | | | | | |
| 32. Registrar's Signature
<i>John Robustiano</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34689

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEAN

E.

BOBO

2. Date of Death

November 2, 1996

3. Time of Death

9:25 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

234-26-9983

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb 22, 1924

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland Allegany

10b. County

Cumberland

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11923 Amherst Ave. NW

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Phillip Hiskel Timbrook

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Bell Loy

19a. Informant's Name/Relationship (Type, Print)

Charles A. Bobo

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11923 Amherst Ave. NW, Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sunset Memorial Park

Date

Nov

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Douglas S. Haler

22. Name and Address of Facility

Hafer Chapel of the Hills Mortuary

1302 National Hwy, La Vale, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Acute Respiratory Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 Days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Cancer of the Lung with Atelectasis

Due to (or as a consequence of):

10 Days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Signature and title of certifier

29c. License number

D 23334

29d. Date signed (Month, Day, Year)

Nov 20, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Dinesh Shah-Johnson Heights Medical Building-Cumberland, MD 21502

31. Date filed (Month, Day, Year)

Nov 06 1996

32. Registrar's Signature

John Johnson

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34690

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harold Edward Butler

2. Date of Death

November 6, 1996

3. Time of Death

2:45 P.M.

4a. Facility Name (If not institution, give street and number)

6099 Amish Road

4b. City, Town, or Location of Death

Grantsville

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

214-03-7117

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 21, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Grantsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6099 Amish Road

10f. Zip Code

21536

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Self-employed Carpenter

16b. Kind of Business/Industry

Carpentry

17. Father's Name (First, Middle, Last)

Melvin Butler

18. Mother's Name (First, Middle, Maiden Surname)

Arminta Durst

19a. Informant's Name/Relationship (Type, Print)

Loretta Miller/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

910 8th St., NW, Canton, Ohio 44700

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Grantsville Cem.

Date

Nov. 8, 1996

20c. Location - City or Town, State

Grantsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A., P.O. Box 275
179 Miller St., Grantsville, MD 21536

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Cardio respiratory arrest +

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

20 min

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

10 days

c. Hypotensive failure

Due to (or as a consequence of):

16 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☒ Yes ☐ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William W. Mark, Jr., M.D., 224 Washington St., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 8 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained. It is a general statement of the work done and the results obtained.

2. The second part of the report deals with the specific work done during the year. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained.

3. The third part of the report deals with the financial statement of the work done during the year. It is a statement of the financial statement of the work done during the year. It is a statement of the financial statement of the work done during the year.

4. The fourth part of the report deals with the conclusions drawn from the work done during the year. It is a statement of the conclusions drawn from the work done during the year. It is a statement of the conclusions drawn from the work done during the year.

5. The fifth part of the report deals with the recommendations made for the future work. It is a statement of the recommendations made for the future work. It is a statement of the recommendations made for the future work.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34691

| | | | | | | | | | |
|--|---|---|---|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IVAN PETER BRADSHAW | | | | 2. Date of Death
Month NOVEMBER Day 3 Year 1996 | | 3. Time of Death
4:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | |
| Funeral
Director | 5. Social Security Number
234-26-4138 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 1, 1907 | | 9. Birthplace (State or Foreign Country)
WV | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
WV | | 10b. County
Mineral | | 10c. City, Town or Location
Ridgeley | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
Rt. 1 Box 158 Scenic LN | | | | 10f. Zip Code
26753 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1936-1939 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) Retired | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry
Western MD Railroad | | |
| | 17. Father's Name (First, Middle, Last)
Robert S. Bradshaw | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Jane (Bodkin) | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
D. Steve Bradshaw-son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1 Box 167 Ridgeley WV 26753 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Ashby Cemetery | | Data
11/05 | | 20c. Location - City or Town, State
Fort Ashby, WV | | |
| | 21. Signature of Funeral Service Licensee
James F. Scarpelli | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. Hypoxemic Respiratory failure
Due to (or as a consequence of):</p> <p>b. Extensive Pulmonary Fibrosis
Due to (or as a consequence of):</p> <p>c. Pneumoconiosis
Due to (or as a consequence of):</p> <p>d. Antracosis</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p>10 days</p> <p>80 years</p> <p>20 years</p> <p>50 years</p> </div> </div> | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Mitral Insufficiency
Left Ventricular failure
Pulmonary Edema | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D13601 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 4th 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
V. R. FELIPA 931 Bishop Walsh Rd Cumberland Md 21502 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a summary of the conclusions.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the theoretical and practical significance of the findings and a summary of the recommendations for further research.

5. The fifth part of the report is a conclusion. It summarizes the main findings of the study and provides a final statement on the importance of the research.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.

8. The eighth part of the report is a list of tables. It includes a list of the tables used in the study and a brief description of each table.

9. The ninth part of the report is a list of figures. It includes a list of the figures used in the study and a brief description of each figure.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34692

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE

PIERCE

BLACK

2. Date of Death

Month

Day

Year

October 27, 1996

3. Time of Death

09:55

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

219-03-9711

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct 31, 1913

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

532 Washington Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Walter L. Pierce

18. Mother's Name (First, Middle, Maiden Surname)

Lucile (Colley)

19a. Informant's Name/Relationship (Type, Print)

Ellen Schmidt--daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 002; Berkeley Springs, WV 25411

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

10/30

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

a. Pulmonary Embolism

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Thirty Minutes

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Deep Vein Thrombophlebitis, Left Leg

Peripheral Arterial Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. R. Barrera

29c. License number

D14865

29d. Date signed (Month, Day, Year)

October 27, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. R. Barrera Memorial Hospital Medical Building Cumberland, Md. 21502

31. Date filed (Month, Day, Year)

NOV 01 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34693

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lonnie V. Bruner

2. Date of Death

November 3, 1996

3. Time of Death

8:30PM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

460-64-4915

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 30, 1917

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State
Virginia

10b. County

10c. City, Town or Location

Norfolk

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3309 Dominion Avenue

10f. Zip Code

23518

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Date: WWII, Korea, Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Warrant Officer

16b. Kind of Business/Industry

US Navy

17. Father's Name (First, Middle, Last)

Robert C. Bruner

18. Mother's Name (First, Middle, Maiden Surname)

Ida Mae Johnston

19a. Informant's Name/Relationship (Type, Print)

Ruth Ann Fodge / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7308 Righters Mill Road, Rockville, Maryland 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Memorial Gardens

Date

Nov. 6, 1996

20c. Location - City or Town, State

Norfolk, Virginia

21. Signature of Funeral Service Licensee

Michael G. Kutta M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic Small Cell Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Eight months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33686

29d. Date signed (Month, Day, Year)

November 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kurt Miller, MD 1811 Prince Philip Dr. Olney, MD 20852

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 06 1996

Julia Davidson-Rodriguez

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

6x1

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34694

Baltimore, Maryland 21215-0020
permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner
Funeral Director
To Be Completed by Funeral Director
Physician /Medical Examiner
Medical Certification: To Be Completed by Physician/Medical Examiner
State Registrar

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
NORMAN JERELL BRYANT | | | | 2. Date of Death
Month NOV. Day 02 , Year 1996 | | 3. Time of Death
3:07 AM. | |
| 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death | |
| 5. Social Security Number
213-86-0451 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
27 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 5, 1969 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Gaithersburg | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
12521 Granite Ridge Drive | | 10f. Zip Code
20878 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 yr | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Lab Technician | | 16b. Kind of Business/Industry
Cytopathological Associates | | 17. Father's Name (First, Middle, Last)
James Schools | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Linda Bryant | | 19a. Informant's Name/Relationship (Type, Print)
Linda Johnson (Mother) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12521 Granite Ridge Dr., Gaithersburg, MD 20878 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olive Church Cem | | 20c. Location - City or Town, State
Lincoln, VA | | 20d. Date
11/9/96 | | 21. Signature of Funeral Service Licensee
 | |
| 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Head and neck injuries
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 23c. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 23d. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24c. Location (Street and Number or Rural Route Number, City or Town, State)
111 Penn Street, Baltimore, Maryland 21201 | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA
Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
11-2-96 | |
| 28b. Time of Injury
2:40 AM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Driving auto: struck a pole & flipped | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
ROAD | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
NOV. 02, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Am Dixon | | 31. Data filed (Month, Day, Year)
NOV 06 1996 | | 32. Registrar's Signature
 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34695

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John F. Peel Brahtz | | | | 2. Date of Death
Month Day Year
November 1, 1996 | | 3. Time of Death
12:23 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
Anne Arundel General Hospital | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
573-10-2668 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
January 29, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Minnesota | | 10a. State
California | | 10b. County
Monterey | | 10c. City, Town or Location
Carmel | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2740 16th Avenue | | 10f. Zip Code
93923 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1941-1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Consulting Engineer | | 16b. Kind of Business/Industry
Research | | | |
| | 17. Father's Name (First, Middle, Last)
John Albert Brahtz | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Charlotte Peel | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lise V. Brahtz/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2740 16th Avenue, Carmel, California 93923 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. | | 20c. Location - City or Town, State
Bethesda, Maryland | | 20d. Date
November 4, 1996 | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> M00846 | | 22. Name and Address of Facility
Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <i>cardiorespiratory arrest</i>
Due to (or as a consequence of):</p> <p>b. <i>acute myocardial infarction</i>
Due to (or as a consequence of):</p> <p>c. <i>coronary artery disease</i>
Due to (or as a consequence of):</p> <p>d.</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p><i>minutes</i></p> <p><i>hours</i></p> <p><i>years</i></p> </div> </div> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>none</i> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> MD | | | | 29c. License number
D23148 | | 29d. Date signed (Month, Day, Year)
11/1/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James W. Ross, 2003 Medical Pkwy., Annapolis, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34696

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond

Birch

2. Date of Death

November 1, 1996

3. Time of Death

1:30 PM

4a. Facility Name (If not institution, give street and number)

12007 Leatherbark Way

4b. City, Town, or Location of Death

Germantown

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

099-14-7639

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 15, 1923

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12007 Leatherbark Way

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Abraham

Birch

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Not Available

19a. Informant's Name/Relationship (Type, Print)

Birsen Birch/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12007 Leatherbark Way, Germantown, Maryland 20874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

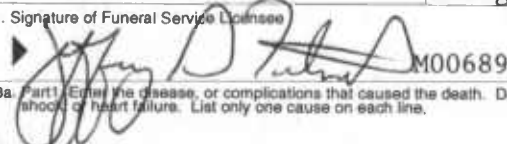
Date

Nov. 2, 1996

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

 M00689

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the lung

Due to (or as a consequence of):

One year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D00009

29d. Date signed (Month, Day, Year)

November 2, 1996

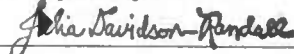
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Adelson, M.D. 2021 K Street, N.W., Washington, DC 20006-1003

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

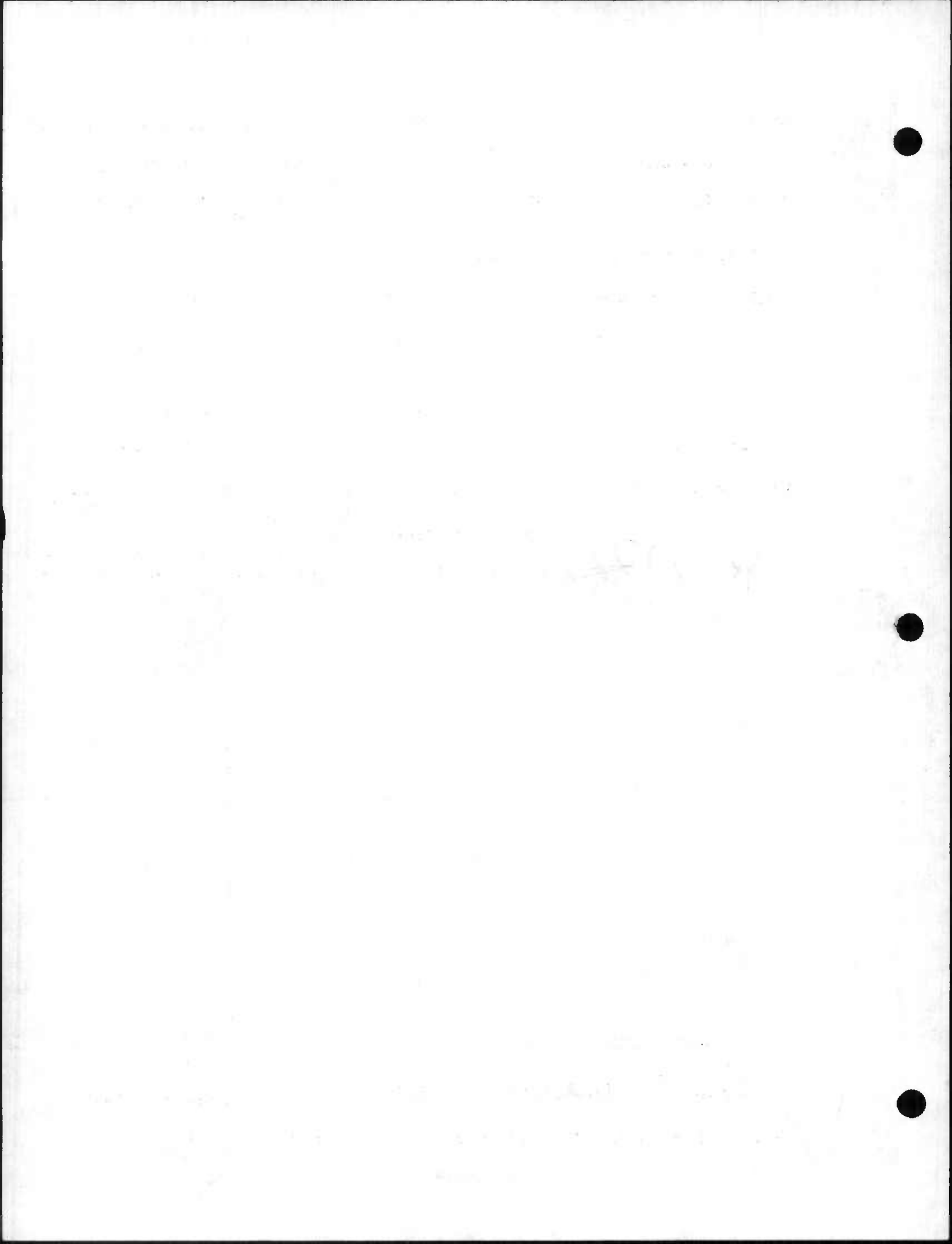
State
RegistrarBaltimore, Maryland 21215-0020
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34697

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Welles Royce Bliss

2. Date of Death

November 2, 1996

3. Time of Death

1:55 A.M.

4a. Facility Name (If not institution, give street and number)

Homewood Retirement Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

177-12-5519

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 27, 1920

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1668 Langley Drive, #402

10f. Zip Code

21740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Episcopal Minister

16b. Kind of Business/Industry

Religion

17. Father's Name (First, Middle, Last)

Wells Royce Bliss

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Heischmann

19a. Informant's Name/Relationship (Type, Print)

Julia E. Barlup

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22144 Holiday Drive, Smithsburg, MD 21783

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

11-3-96

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous CABG x2

Normal Pressure Hydrocephalus

Abdominal Aortic Aneurysm

Parkinson's like syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James S. Grissom M.D.

29c. License number

D21944

29d. Date signed (Month, Day, Year)

11/21/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James S. Grissom M.D., 300 W 9th St, Frederick, Md 21701

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34698

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
JUNE BARBARA BAILEY | | | | 2. Date of Death
Month NOV Day 6 Year 1996 | | 3. Time of Death
9:10 AM | |
| 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| 5. Social Security Number
218-30-2502 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 12, 1936 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10. Usual Residence of Decedent
10e. State Maryland 10b. County Montgomery 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10f. Zip Code
20901 | |
| 10g. Citizen of What Country?
United States | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Office manager | | 16b. Kind of Business/Industry
Wholesale Auto Parts | |
| 17. Father's Name (First, Middle, Last)
Louis G. Tucker, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Hamilton | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Robert M. Bailey | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Date
11-7-96 | | 20c. Location - City or Town, State
Beltsville, Maryland | |
| 21. Signature of Funeral Service Licensee
Deleen H. Rapp | | | | 22. Name and Address of Facility
Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910 | | | |

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

| | | | |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis
Due to (or as a consequence of):
b. pneumonia
Due to (or as a consequence of):
c. chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
1 day
2 weeks
long-standing | |
|--|--|--|--|

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LuPaul Ketting MD 2101 Medical Park Drive Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

Phia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34699

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET E. BUSH

2. Date of Death

Month Day Year
NOV. 4, 1996

3. Time of Death

1:00 PM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOME, INC.

4b. City, Town, or Location of Death

HYATTSVILLE

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

577-14-4645

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 20, 1898

9. Birthplace (State or Foreign Country)

WASH. D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

FORESTVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2110 TIBER DR.

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

FED. GOV'T.

17. Father's Name (First, Middle, Last)

WILLIAM JONES

18. Mother's Name (First, Middle, Maiden Surname)

MARY O. CARTER

19a. Informant's Name/Relationship (Type, Print)

RENEE M. GARNES-SPENCE/GRANDDAUGHTER SAME AS ITEM #10

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. OLIVET CEMETERY

Date

11/9

20c. Location - City or Town, State

WASHINGTON, D.C.

21. Signature of Funeral Service Licensee

W. W. Chambers M00091

22. Name and Address of Facility

W. W. CHAMBERS CO., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. EMBOLISM OF FOOT
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. HYPERTENSIVE CARDIOVASCULAR DISEASE - EMBOLIC
Due to (or as a consequence of): EMBOLISM

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

14 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P STROKE

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

MARTHA A. SCHNEIDER MD

29c. License number

D26331

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTHA A. SCHNEIDER MD 5501 MARYLAND BLVD NW WASH DC 20016

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34700

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD

BROWNING

2. Date of Death

Month

Day

Year

NOV. 5,

1996

3. Time of Death

8:35 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ROCKVILLE NURSING HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

092-10-8892

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

APRIL 13,

1915

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

12604 EASTBOURNE DRIVE

10f. Zip Code

20904

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

MECHANICAL ENGINEER

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

MORRIS BROWNSTEIN

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE WEXLER

19a. Informant's Name/Relationship (Type, Print)

ROGER K. BROWNING (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7341 OSKALOOSA DRIVE - ROCKVILLE, MARYLAND 20855

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. COMFORT CREMATORY

Date

11/8/96

20c. Location - City or Town, State

ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CEREBROVASCULAR ACCIDENT

WKS. - MONTHS

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

WKS.

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

YRS.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 8 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D02404

29d. Date signed (Month, Day, Year)

NOVEMBER 5, 1996

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ALLAN H. GROLLMAN, MD - 1106 SPRING STREET - SILVER SPRING, MARYLAND 20910

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

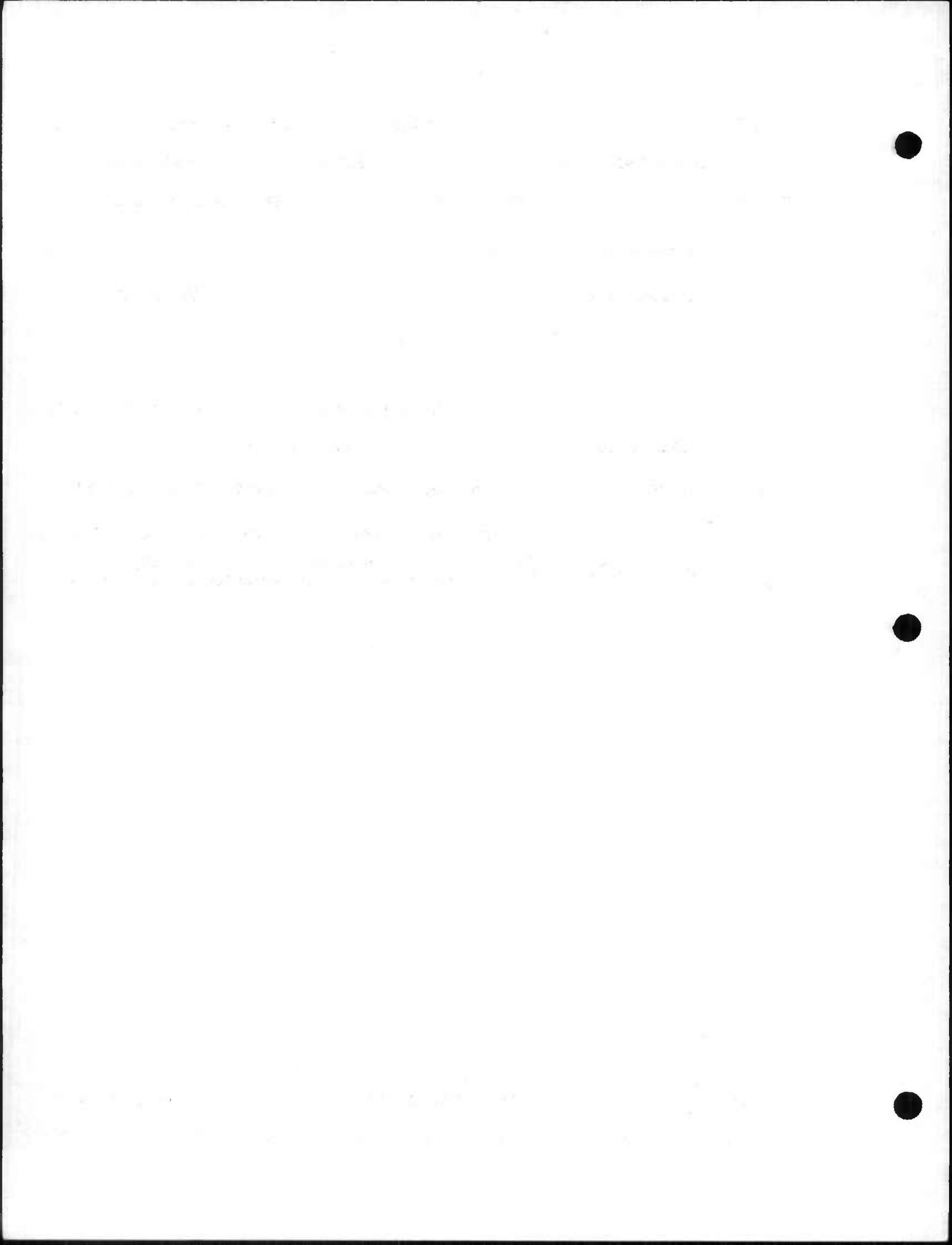
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34701

| | | | | | | | | | | | | |
|---|---|--|--|---|--|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LENA DORA CLARK | | | | 2. Date of Death
Month Day Year
NOVEMBER 3, 1996 | | | | 3. Time of Death
7:04pm | | | |
| | 4a. Facility Name (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL | | | | 4b. City, Town, or Location of Death
LANHAM-SEABROOK | | | | 4c. County of Death
PRINCE GEORGE'S CO. | | | |
| Funeral
Director | 5. Social Security Number
180-34-3725 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
54 Yrs. | | 8. Date of Birth (Month, Day, Year)
January 15, 1942 | | 9. Birthplace (State or Foreign Country)
Virginia | | | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | | | 10b. County
Prince Georges | | | |
| 10c. City, Town or Location
Riverdale | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 10e. Street and Number
6841 Riverdale Road, Apt. D-101 | | | | 10f. Zip Code
20737 | | | | 10g. Citizen of What Country?
United States | | | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 years College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | | | |
| 16b. Kind of Business/Industry
US Dept. of Treasury Internal Revenue Service | | | | 17. Father's Name (First, Middle, Last)
Sweet Love Clark | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hallie Payne | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Doris Ann Clark (sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6841 Riverdale Road, Apt. D-101; Riverdale, Maryland 20737 | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Triumph Baptist Church Cemetery | | | | 20c. Location - City or Town, State
Chatmon, Virginia | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Latney's Funeral Home, Inc. 3831 Georgia Avenue, N.W.; Washington, D.C. 20011 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
METASTATIC LEIOMYOSARCOMA
Due to (or as a consequence of):
PLEURAL EFFUSION
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
3 YRS.
1 WEEK | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier

DR. CHITRA VENKATARAMAN | | | | |
| 29c. License number
041715 | | | | 29d. Date signed (Month, Day, Year)
11. 4. 96 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHITRA VENKATARAMAN MD, 4343 Hanover Parkway, Greenbelt, MD 20770 | | | | |
| 31. Date filed (Month, Day, Year)
NOV 06 1996 | | | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34702

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEANNE D. CONTARINO

2. Date of Death

Month Day Year
NOV - 2 1996

3. Time of Death

11:02 pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-30-6731

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 28, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Berwyn Heights

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6207 Quebec Place

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

St. Elmo Earl Ball

18. Mother's Name (First, Middle, Maiden Surname)

Grace Darling Creel

19a. Informant's Name/Relationship (Type, Print)

Joseph Contarino, Jr.-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6207 Quebec Place, Berwyn Heights, Md. 20740

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

11/6/96

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Henry S. Ball

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, Md 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. CVA
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Aortic valve replacement
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DR. FAYAZ SHAWL

29c. License number

D22639

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. FAYAZ SHAWL 7600 CARROLL AVE. TAKOMA PARK, MD. 20912

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

John A. Russell

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34703

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR Covington

2. Date of Death
Month Day Year

OCT. 30 96

3. Time of Death

12:30AM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore (City)

4c. County of Death

Funeral
Director

5. Social Security Number

238-16-7533

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 1, 1910

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1701 Eutaw Place

10f. Zip Code

21217

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Baker

16b. Kind of Business/Industry

Bakery

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Betsy Covington

19a. Informant's Name/Relationship (Type, Print)

Mildred Harris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 E. Forest Oaks Drive Sanford, NC 27330

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ward Memorial Church Cem.

Date

11/4/96

20c. Location - City or Town, State

Sanford, NC

21. Signature of Funeral Service Licensee

#M00690

Howard W. Carson

22. Name and Address of Facility

Horton Funeral Home
604 South Horner Boulevard, Sanford, NC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Bilateral pneumonia.
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute renal failure
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Mrowiec

29c. License number

D47804

29d. Date signed (Month, Day, Year)

10/30/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A. Mrowiec, ST. Edward Family Center

2846 W. Lafayette Ave. Baltimore, MD 21216

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

John A. Howard-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 34704

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Marie Conner | | | | 2. DATE OF DEATH
MONTH DAY YEAR
November 3, 1996 | | | | 3. TIME OF DEATH
1:00 AM M | | | | | |
| 4. SOCIAL SECURITY NUMBER
105-14-6361 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct. 16, 1907 | | 8. BIRTHPLACE (State or Foreign Country)
Hancock, NY | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Asbury Methodist Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Gaithersburg | | | | 9c. COUNTY OF DEATH
Montgomery | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Silver Spring | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
12502 Bushey Drive | | | | 10f. ZIP CODE
20906 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Owner | | 15b. KIND OF BUSINESS/INDUSTRY
Hotel | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Matthew White | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Lena Keller | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Linda Berger - Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12502 Bushey Drive Silver Spring, Maryland | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Paul's Cemetery 4/15/1997 | | 20c. LOCATION — City or Town, State
Hancock, New York | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Allen W. Howe</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Henderson, Beidekapp Funeral Home
7 East Main Street Hancock, New York | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cerebrovascular accident</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>hypertension, prior CVA, stroke, diabetes, heart</i>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29c. LICENSE NUMBER
D03581 | | 29d. DATE SIGNED (Month, Day, Year)
11/3/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ELLIOT R. GOLDSTEIN 9410 OLD GEORGETOWN RD NOV. 3 96 | | | | | | | | | | 31. DATE FILED (Month, Day, Year)
NOV 05 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John Anderson Randall</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34705

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Merl William Click, Jr.

2. Date of Death

November 3, 1996

3. Time of Death

11:40 P.M.

4a. Facility Name (If not institution, give street and number)

4407 Unaka Court

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-28-1797

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 24, 1926

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4407 Unaka Court

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Merl W. Click, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rose Reed

19a. Informant's Name/Relationship (Type, Print)

Virginia I. Click/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4407 Unaka Ct., Clinton, Maryland 20735

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

11/4/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ADVANCED adenocarcinoma, RT
Due to (or as a consequence of): lung

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. status post emaciation
Due to (or as a consequence of): Post Chemotherapy
c. and x-ray therapy
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-14068

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manoutchehr Moasser, M.D. 16005 Crain Highway, Brandywine, Md. 20613-8082

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

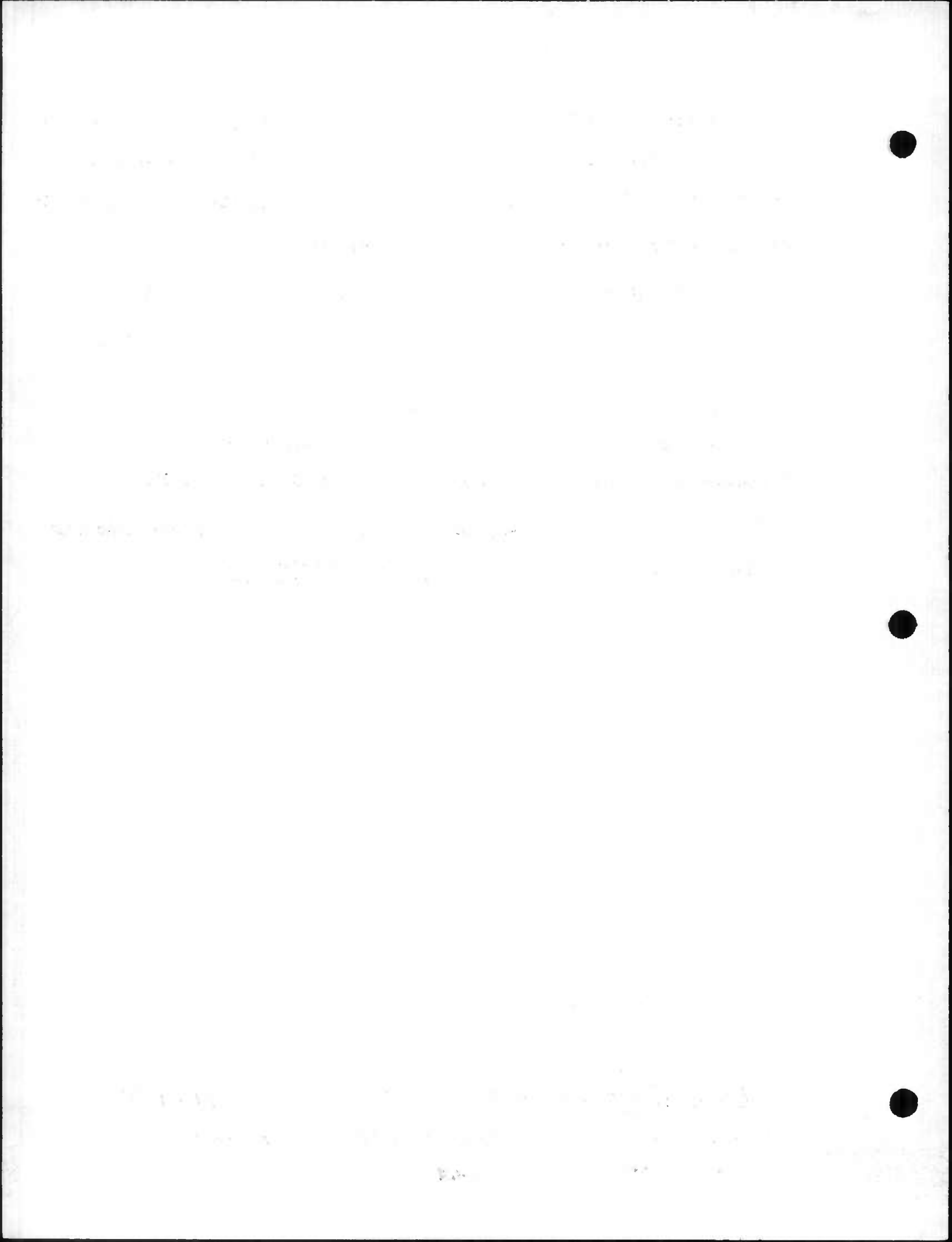
96 34706

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JESSE CAUTHEN | | | | 2. Date of Death
Month: Nov Day: 1 Year: 1996 | | 3. Time of Death
1:55 AM | |
| | 4a. Facility Name (If not institution, give street and number)
HOLY CROSS HOSPITAL | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
248-38-8526 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
02-20-30 | |
| | 9. Birthplace (State or Foreign Country)
South Carolina | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Glenarden | |
| To Be Completed by Funeral Director | 10e. Street and Number
1414 Wesley Street | | | | 10f. Zip Code
20706 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th Collage (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Custodian | | 16b. Kind of Business/Industry
Government | |
| | 17. Father's Name (First, Middle, Last)
Eddie Cauthen | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maggie Cauthen | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Elizabeth Cauthen/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1414 Wesley Street, Glenarden, MD 20706 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Cemetery | | 20c. Location - City or Town, State
Landover, Maryland | | 20d. Date
11/7/96 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Nancy A. Perentie | | | | 22. Name and Address of Facility
J. B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____ | | | | Approximate Interval Between Onset and Death
4 weeks | | | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| State Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
David A. Garcia, M.D. | | 29c. License number
D50367 | |
| | 29d. Date signed (Month, Day, Year)
11/1/96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID A. GARCIA HOLY CROSS HOSPITAL SILVER SPRING, MD | | | | | |
| DHMH 16 Rev 6/95 | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | | | 32. Registrar's Signature
John Davidson-Randall | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34707

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Troy Coleman

2. Date of Death

Month Day Year
Nov 4, 1996

3. Time of Death

5:17pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

227-18-8408m

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

June 17, 1922 Virginia

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington DC

10d. Inside City Limits

1 ☒ 2 ☐ No

10e. Street and Number

436 Riggs Rd NE

10f. Zip Code

20011

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 194213. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Quinsby H. Coleman

18. Mother's Name (First, Middle, Maiden Surname)

Mary L. Coleman

19a. Informant's Name/Relationship (Type, Print)

Inze E. Coleman Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

436 Riggs Rd NE Wash DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Beulah Church Cemetery Nov 11 1996 Spotsylvania

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

Bailey Funeral Home

1201 White St Fredericksburg Va

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 mo

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

29c. License number

D 40710

29d. Date signed (Month, Day, Year)

Nov 5, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEPHEN GORDON, MD

1160 VARNUM ST, NE, STE 114
WASHINGTON, DC 20017

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 96 34708

Reg. No.

DMMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34709

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James Copeland | | | 2. Date of Death
Month October Day 22 Year 1996 | | | 3. Time of Death
8:00 AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital | | | 4b. City, Town, or Location of Death
Baltimore | | | 4c. County of Death
Baltimore | | | | | | |
| Funeral
Director | 5. Social Security Number
262-40-7279 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 22, 1926 | | 9. Birthplace (State or Foreign Country)
Alabama | | | | |
| | Usual Residence of Decedent | | | 10a. State
MD | | | 10b. County
City | | | 10c. City, Town or Location
Baltimore | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 10e. Street and Number
6-J Aspinwoodway | | | 10f. Zip Code
21237 | | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
cook | | | 16b. Kind of Business/Industry
civil service | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Joseph Copeland | | | 18. Mother's Name (First, Middle, Maiden Summa)
Alberta Green | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Roslyn Copeland | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6-J Aspinwoodway Baltimore, MD 21237 | | | | | | | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest | | | Date
10-28-96 | | | 20c. Location - City or Town, State
Owings Mills, MD | | | |
| | 21. Signature of Funeral Service Licenses
 | | | 22. Name and Address of Facility
Beard Funeral Home
Havre de Grace, MD 21078 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Tension Pneumothorax
Due to (or as a consequence of):
b. Pleural Effusion
Due to (or as a consequence of):
c. Lung Cancer
Due to (or as a consequence of):
d. | | | Approximate Interval Between Onset and Death | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | 24e. Was an autopsy performed?
1 Yes 2 No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | |
| | 25. Was case referred to medical examiner?
1 Yes 2 No | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | | 28a. Date of Injury (Month, Day Year) | | | 28b. Time of Injury
M | | | 28c. Injury at Work?
1 Yes 2 No | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | 29c. License number
AS24023214C9031 | | | 29d. Date signed (Month, Day, Year)
October 22, 1996 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
L. Cunningham Sinai Hospital | | | 31. Date filed (Month, Day, Year)
OCT 28 1996 | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34710

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Kenneth Bernel Christy | | 2. Date of Death
Month November Day 03 Year 1996 | | 3. Time of Death
0625 | |
| 4a. Facility Name (If not institution, give street and number)
ER Harford Memorial Hospital | | 4b. City, Town, or Location of Death
Havre De Grace | | 4c. County of Death
Harford | |
| 5. Social Security Number
220-20-1825 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
01-02-1929 |
| 9. Birthplace (State or Foreign Country)
MD | | | | | |
| 10a. State
MD | | 10b. County
Harford | | 10c. City, Town or Location
Havre de Grace | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
559 Lewis Street | | | 10f. Zip Code
21078 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1951-53 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Utility Man | | 16b. Kind of Business/Industry
Self Employed |
| 17. Father's Name (First, Middle, Last)
William Henry Christy, Jr. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary M. R. Cole | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. Harford Williams - Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
49 Jefferson Avenue, Bristol, PA 19007 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. James Cemetery | | Date
11/8/96 | 20c. Location - City or Town, State
Havre de Grace, MD |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Active GI Bleeding
a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ASCVD | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
NA | 28b. Time of Injury
NA M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred
NA |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
NA | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
NA | |
| 29e. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
DME | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
NOV 4th 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
G.S. Prabhu 1810 Belair Rd Fallston MD. 21047 410-879-6564. | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 6 1996 | | 32. Registrar's Signature
 | | | |

State Registrar

[Faint, illegible text, likely bleed-through from the reverse side of the page]

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Glenn LEROY Crowl | | | 2. Date of Death
Month October Day 21 Year 1996 | | | 3. Time of Death
4:15 PM | | | |
| 4a. Facility Name (If not institution, give street and number)
Bel Air Convalescent & Nursing Center | | | 4b. City, Town, or Location of Death
Bel Air | | | 4c. County of Death
Harford | | | |
| 5. Social Security Number
219-36-0033 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | | 8. Date of Birth (Month, Day, Year)
6/7/03 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Harford | | 10c. City, Town or Location
Street | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10a. Street and Number
300 Cherry Hill Road | | | 10f. Zip Code
21154 | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) 4 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Farmer | | | 16b. Kind of Business/Industry
Agriculture | | | |
| 17. Father's Name (First, Middle, Last)
James Warfield Crowl | | | 18. Mother's Name (First, Middle, Maiden Surname)
Cornelia Jane Coale | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ruth Ann Crowl/niece | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
201 Cherry Hill Rd., Street, MD 21154 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highland Cemetery | | | 20c. Location - City or Town, State
10/24/96 Street, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Harkins F.H.Inc., Delta, PA 17314 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. bladder cancer
Due to (or as a consequence of): transferred cell

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | Approximate Interval Between Onset and Death
1 year & | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
peripheral vascular disease
chronic lung
coronary artery disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No NA | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
D28136 | | 29d. Date signed (Month, Day, Year)
10-22-96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
615 W. Mosebrook Rd Bel Air MD 21014 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
OCT 23 1996 | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34712

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVA BONNIE COOPER

2. Date of Death

November 7 1996

3. Time of Death

11:15 am

4a. Facility Name (If not Institution, give street and number)

3313 Woodland Acres

4b. City, Town, or Location of Death

East New Market

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

235-54-5462

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 25 1914

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

W VA

10b. County

Randolph

10c. City, Town or Location

Harman

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

U.S. Route 33

10f. Zip Code

26270

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

James C. Harman

18. Mother's Name (First, Middle, Maiden Surname)

Martha Blizzard

19a. Informant's Name/Relationship (Type, Print)

Mr. Darryl V. Harman - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3313 Woodland Acres, East New Market MD 21631

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Davis Cemetery

Date

11-9-1996

20c. Location - City or Town, State

Davis West Virginia

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home PA
700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Adenocarcinoma of unknown primary 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edmund J. MacLaughlin

29c. License number

D28209

29d. Date signed (Month, Day, Year)

NOVEMBER 7, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

EDMUND J. MACLAUGHLIN, MD 4 AURORA ST., CAMBRIDGE, MD. 21613

31. Date filed (Month, Day, Year)

NOV 12 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34713

Certificate of Death


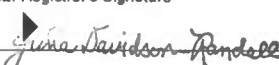
Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Bessie McFern Coughenour | | | | 2. Date of Death
Month 11 Day 03 Year 96 | | 3. Time of Death
5:25 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Caroline Nursing Home, Inc. | | | | 4b. City, Town, or Location of Death
Denton, Maryland | | 4c. County of Death
Caroline | |
| Funeral
Director | 5. Social Security Number
217-10-2046D | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
101 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
9/23/1895 | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Caroline | | 10c. City, Town or Location
Denton | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
520 Kerr Avenue | | | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | |
| 17. Father's Name (First, Middle, Last)
William McFern | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Sherer | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Edgar A. Coughenour | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21 Eagle Drive, Emerson, NJ 07630 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hill Crest Cemetery | | Date
11/5 | | 20c. Location - City or Town, State
Federalsburg, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Frampton-Hawkins-Eskow Funeral Home
P.O. Box 43, Federalsburg, MD 21632 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Pulmonary Embolism
Due to (or as a consequence of):
b. Fractured Pelvis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate interval Between Onset and Death
hours | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | | | |
| 29c. License number
D3137C | | 29d. Date signed (Month, Day, Year)
11-4-96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James Sides 920 Market St., Denton, MD 21629 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV - 6 '96 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 505.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34714

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EARL R. COHEE, SR.

2. Date of Death

Month

Day

Year

3. Time of Death

0040

Funeral
Director

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM, BALTIMORE, MD

4b. City, Town, or Location of Death

BALTIMORE, MD

4c. County of Death

BALTIMORE CITY

5. Social Security Number

214-34-8689

6. Sex

XXM 2 F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

04/16/37

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

23201 Gilpin Point Road

10f. Zip Code

21655

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Poultry Farmer

16b. Kind of Business/Industry

Poultry

17. Father's Name (First, Middle, Last)

Benjamin Cohee

18. Mother's Name (First, Middle, Maiden Summa)

Mary E. Williamson

19a. Informant's Name/Relationship (Type, Print)

Jeanette M. Cohee/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23201 Gilpin Point Rd., Preston, MD 21655

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Junior Order Cemetery

Date

11/16

20c. Location - City or Town, State

Preston, Maryland

21. Signature of Funeral Service Licensee

Michael J. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home

PO Box 43, Federalburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

CARDIOVASCULAR COLLAPSE

Due to (or as a consequence of):

b.

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

d.

MILITARY VALVE PROLAPSE

Approximate Interval Between Onset and Death

5 DAYS

YEARS

5 DAYS

1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary hypertension

Severe coagulopathy

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

28. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenneth E. Sauer

29c. License number

AU476433AS2134

29d. Date signed (Month, Day, Year)

Nov 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNETH E. SAUER MD - 225 GREEVE ST. BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

NOV 13 '96

32. Registrar's Signature

J. Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34715

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEE

CHANEY

2. Date of Death
Month Day Year

NOVEMBER 1

1996

15:00

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

220-16-6660

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEB. 1, 1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CRESAPTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14919 LONE OAK ROAD

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FLAGMAN

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

LEE H. CHANEY

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET WHITE

19a. Informant's Name/Relationship (Type, Print)

MARY CHANEY / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14919 LONE OAK ROAD, CRESAPTOWN, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

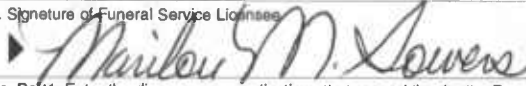
FROSTBURG MEMORIAL PARK 11/4/96

Date

20c. Location - City or Town, State

FROSTBURG, MD 21532

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.
60 W. MAIN ST., FROSTBURG, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Congestive Heart Failure

Due to (or as a consequence of):

Atrial Fibrillation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 Week

1 Week

1 Week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

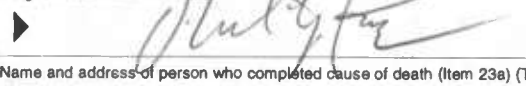
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 36766

29d. Date signed (Month, Day, Year)

11/4/96

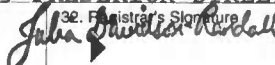
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. VIK POONAI, 455 FREDERICK STREET, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature



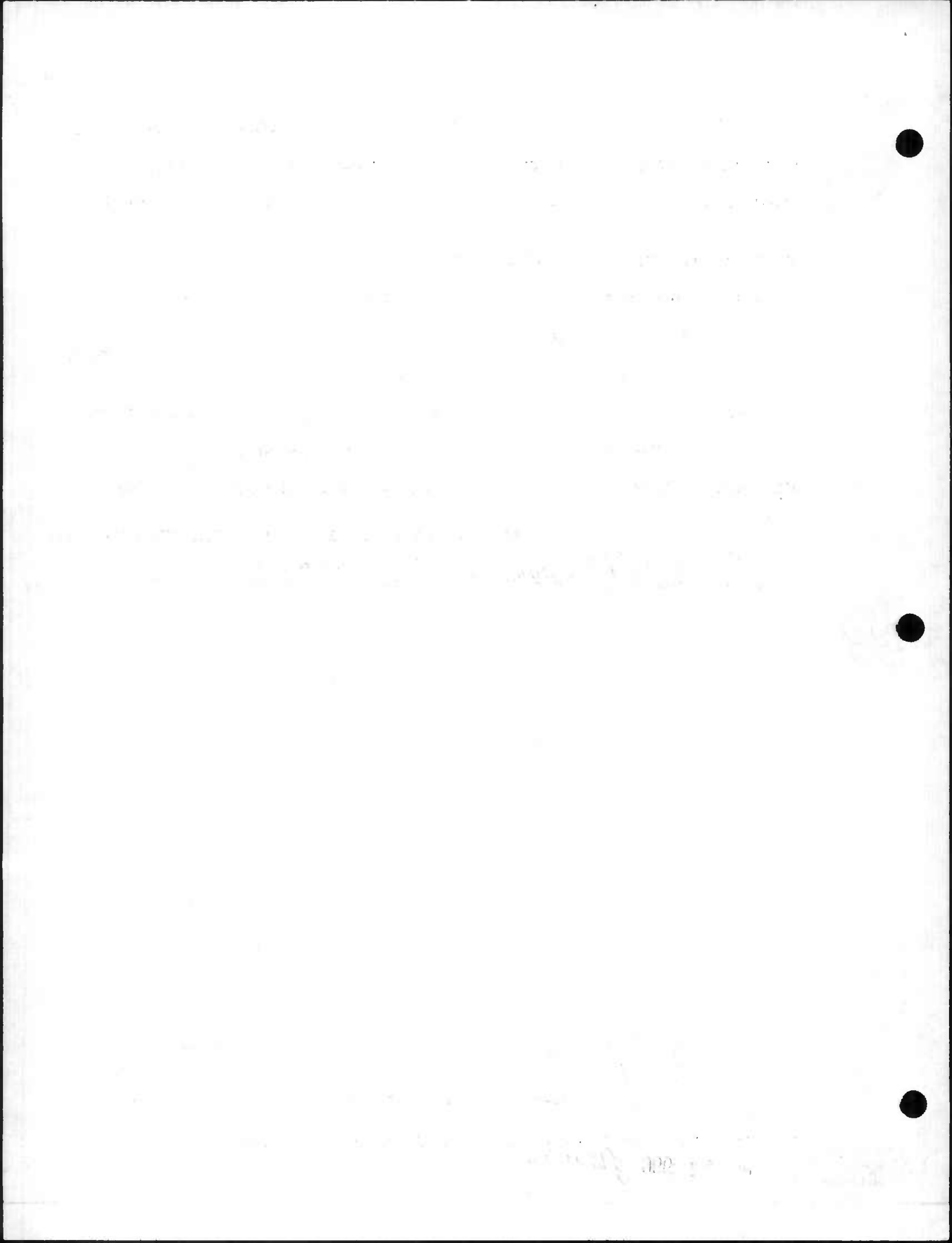
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34716

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Laura Grace Conrad

2. Date of Death
Month Day Year

10 31 96

3. Time of Death

19:46

Funeral
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

220-10-9038

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

101

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 15, 1895

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1158 Luther Drive

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired

16b. Kind of Business/Industry

Fairchild Industry

17. Father's Name (First, Middle, Last)

Michael J. Hinds

18. Mother's Name (First, Middle, Maiden Surname)

Millie Frances (Gilhart)

19a. Informant's Name/Relationship (Type, Print)

Martin Radinsky

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 919; Hagerstown, MD 21740

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SS Peter Paul Cemetery

Date

11/04

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute Pulmonary Edema

Approximate Interval Between Onset and Death

3hr.

Due to (or as a consequence of):

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Organic Heart Disease.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary E. Money MD

29c. License number

D23815

29d. Date signed (Month, Day, Year)

10/31/96.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary E. Money, MD 354 Mill Street, Hagerstown, MD 21740.

31. Date filed (Month, Day, Year)

NOV 01 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34717

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JESS R. CONNER

2. Date of Death
Month Day Year
October 25, 1996
3. Time of Death
3:50 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

215-76-1389

6. Sex

12 M 2 F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

Feb 18, 1955

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

110 Park Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 X Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Painting

17. Father's Name (First, Middle, Last)

Jess W. Conner

18. Mother's Name (First, Middle, Maiden Surname)

Delores (nmn)

19a. Informant's Name/Relationship (Type, Print)

Delores Jessie--mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

261 N. Centre Street; Cumberland, MD 21502

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hillcrest Memorial Park

Date

10/28

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 21502

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiorespiratory Arrest

Due to (or as a consequence of):

20 minutes

b. Sepsis

Due to (or as a consequence of):

7 Days

c. Hepatic Failure

Due to (or as a consequence of):

7 Days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy
performed?

1 Yes 2 X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 X No

25. Was case referred to medical
examiner?

1 Yes 2 X No

Hospital:

1 X Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation
6 X Could not be
determined

28a. Date of Injury
(Month, Day Year)

28b. Time of
injury

28c. Injury at
Work?
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 31221

29d. Date signed (Month, Day, Year)

October 31 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mark, 224 Washington St., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 01 1996

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34718

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last) aka RUTHVEN BENJAMIN COOPER | | | | 2. Date of Death
Month Day Year
October 30, 1996 | | 3. Time of Death
2:00 am | |
| | 4a. Facility Name (If not institution, give street and number)
12112 Dalewood Drive | | | | 4b. City, Town, or Location of Death
Wheaton | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
316-69-7018 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 5, 1929 | |
| | 9. Birthplace (State or Foreign Country)
Trinidad | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Wheaton | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
12112 Dalewood Drive | | 10f. Zip Code
20902 | | 10g. Citizen of What Country?
Trinidad | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Maintenance Worker | | 16b. Kind of Business/Industry
Private Industry | | | | |
| 17. Father's Name (First, Middle, Last)
Simeon Cooper | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Adelada Duntin | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Angela H. Cooper (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12112 Dalewood Dr., Wheaton, Md. 20902 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Washington Cem. | | Date
11/4/96 | | 20c. Location - City or Town, State
Adelphi, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
R. N. Horton Co. Morticians, Inc.
600 Kennedy Street, N.W. DC 20011 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA OF THE STOMACH
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death
2 YEARS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | | | |
| | | 29c. License number
D14686 | | 29d. Date signed (Month, Day, Year)
10/31/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARTIN S. ROSENTHAL MD, 10810 CONNECTICUT AVE., KENNESAW TOWN, MD. 20895 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 06 1996 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34719

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eva Marie Cassidy

2. Date of Death

November 2, 1996

3. Time of Death

12:02 AM

4e. Facility Name (If not institution, give street and number)

6604 Highbridge Road

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

217-68-6796

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 2, 1963

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6604 Highbridge Road

10f. Zip Code

20720

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Musician

16b. Kind of Business/Industry

Entertainment

17. Father's Name (First, Middle, Last)

Hugh T. Cassidy

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Kraetzer

19a. Informant's Name/Relationship (Type, Print)

Hugh & Barbara Cassidy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

11-2-96

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Melanoma

Approximate Interval Between Onset and Death

3 months

Due to (or as a consequence of):

b. Primary Melanoma

3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter Eckberg, M.D.

29c. License number

D35820

29d. Date signed (Month, Day, Year)

November 2, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Peter Eckberg, M. D., 14300 Gallant Fox Lane, #110, Bowie, MD 20715

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

The Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34720

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | |
|---|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)
TERRY G. CHANEY | | | 2. Date of Death
Month NOVEMBER Day 04 Year 1996 | | 3. Time of Death
0117 |
| 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY |
| 5. Social Security Number
212-72-9598 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
42 Yrs. | If Under 1 Year
Months 0 Days 0 | If Under 24 Hrs.
Hours 0 Min. 0 | 8. Date of Birth (Month, Day, Year)
July 20, 1954 |
| 9. Birthplace (State or Foreign Country)
Maryland | | | | | |

Funeral
Director

| | | | | | | |
|--|--|---|--|--|--|--|
| Usual Residence of Decedent | | 10a. State
MD | | 10b. County
Montgomery | 10c. City, Town or Location
Gaithersburg | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
730 Clopper Road, #11 | | 10f. Zip Code
20878 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
10th | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
State Rd. Comm. | | |

To Be Completed by Funeral Director

| | | | |
|---|--|--|--|
| 17. Father's Name (First, Middle, Last)
Henry J. Chaney, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Ida Mae Nolan | |
| 19a. Informant's Name/Relationship (Type, Print)
Helen M. Chaney (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
730 Clopper Rd., #11, Gaithersburg, MD 20878 | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
John Wesley Cemetery | |
| 20c. Date
11/9/96 | | 20d. Location - City or Town, State
Clarksburg, MD | |

| | |
|---|---|
| 21. Signature of Funeral Service Licensed
<i>[Signature]</i> | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 |
|---|---|

Physician
/Medical
Examiner

| | | |
|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Cerebral hemorrhage
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
Day
years |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | |
| | | |
| | | |

| | | | |
|--|--|--|---|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal insufficiency | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | |
|---|---|--|---|
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | | | |
|---|-------------------------------------|--|--|
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier
Alan S. Chanaler MD | 29c. License number
29453 | 29d. Date signed (Month, Day, Year)
November 4, 1996 | |

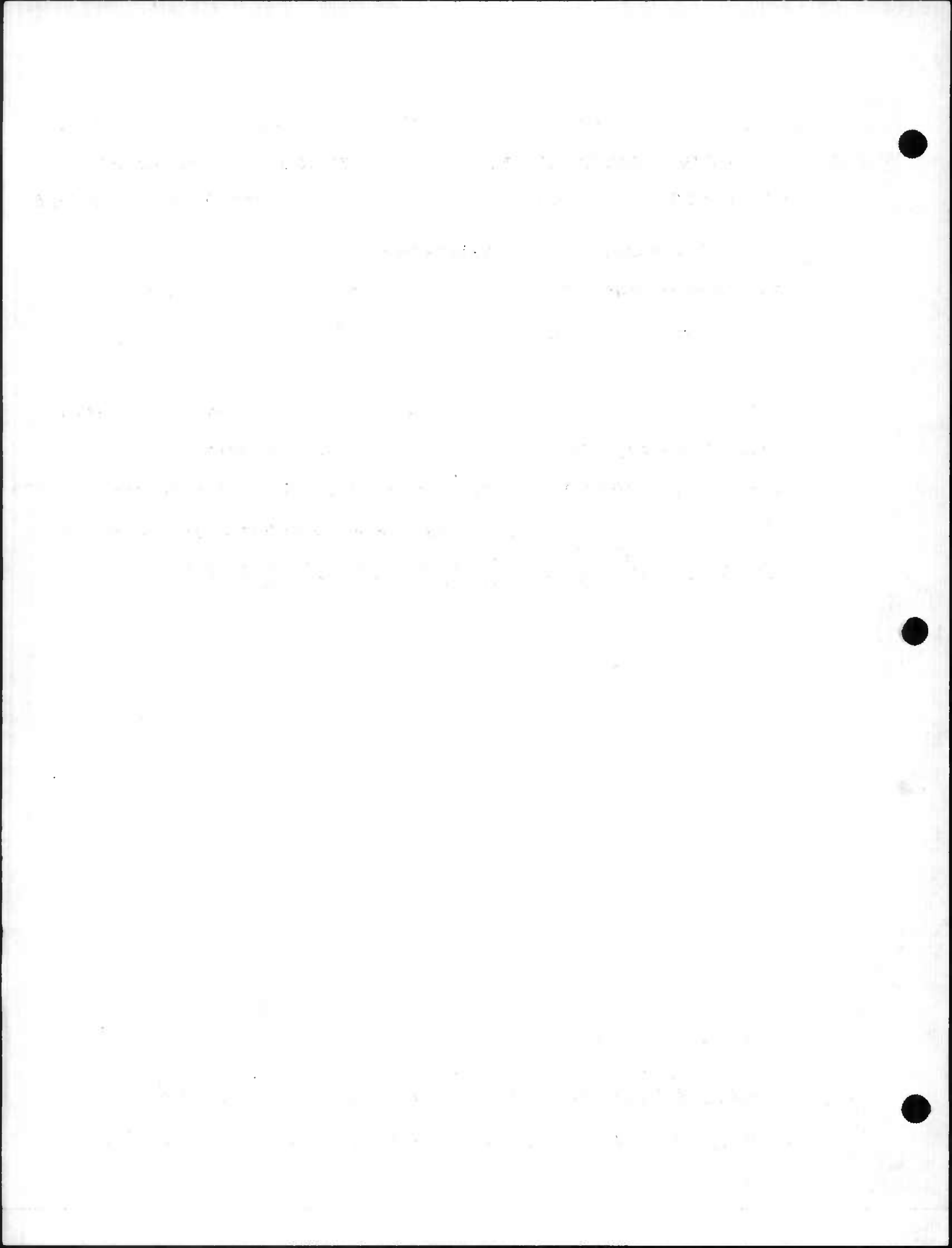
| | |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ALAN S. CHANALER 15225 SHADY GROVE RD ROCKVILLE MD 20850 | |
|---|--|

| | |
|---|---|
| 31. Date filed (Month, Day, Year)
NOV 06 1996 | 32. Registrar's Signature
<i>[Signature]</i> |
|---|---|

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34721
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---------------------------|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Alfred F. Constantino | | | | 2. Date of Death
Month Day Year
October 31, 1996 | | | | 3. Time of Death
1:35 A.M. | | |
| | 4a. Facility Name (If not Institution, give street and number)
Montgomery General Hospital | | | | 4b. City, Town, or Location of Death
Olney | | | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
021-09-3663 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
Mar. 21, 1914 | | 9. Birthplace (State or Foreign Country)
Massachusetts | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
10011 Grayson Avenue | | | | 10f. Zip Code
20901 | | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | | | 16b. Kind of Business/Industry
Construction | | | |
| 17. Father's Name (First, Middle, Last)
Bonifacio Constantino | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Pasqualina Unobtainable | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Archina Smith - Friend | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1011 Grayson Avenue, Silver Spring, Maryland 20901 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Puritan Lawn Memorial Pk. | | Date
11/6/96 | | 20c. Location - City or Town, State
West Peabody, MA | | | |
| 21. Signature of Funeral Service Licensee
<i>Charles S. Justice</i> | | | | | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Pneumonia</i>
Due to (or as a consequence of):
b. <i>Bilateral pacemaker site infection</i>
Due to (or as a consequence of):
c. <i>Refractory Anemia</i>
Due to (or as a consequence of):
d. <i>History of Bradyarrhythmia</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
<i>Oct 1996</i>
<i>1996</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>History of Gastrointestinal arterio-venous malformation with Bleeding</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>William J. Ninala</i> | | | | 29c. License number
D45285 | | | | 29d. Date signed (Month, Day, Year)
October 31, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wilkinson J. Ninala, M.D., 18111 Prince Philip Drive, Olney, Maryland 20832, Suite 212 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | 32. Registrar's Signature
<i>Johia Davidson-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34722

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edmund R. Dillas

2. Date of Death

November 3, 1996

3. Time of Death

9:28a

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral
Director

5. Social Security Number

None

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
December 9, 1928

9. Birthplace (State or Foreign Country)

Bermuda

Usual Residence of Decedent

10a. State

Bermuda

10b. County

None

10c. City, Town or Location

Warwick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2 Crossend Lane

10f. Zip Code

WK05

10g. Citizen of What Country?

Bermuda

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tiler

16b. Kind of Business/Industry

Ceramic Tile Company

17. Father's Name (First, Middle, Last)

Adolphus Dillas

18. Mother's Name (First, Middle, Maiden Surname)

Marion (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Gladys L. Dillas - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Crossend Lane, Warwick, Bermuda WK05

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. John's Cemetery

Date

11/9/96

20c. Location - City or Town, State

Pembroke, Bermuda

21. Signature of Funeral Service Licensee

Claudette S. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave, Hyattsville, Md. 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. electro-mechanical disassociation

Approximate
Interval Between
Onset and Death

minutes

Due to (or as a consequence of):

b. bradycardia

1 hour

Due to (or as a consequence of):

c. acidemia

3 days

Due to (or as a consequence of):

d. multiple organ failure

7 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

James R. Blair, MD

29c. License number

R65-000

29d. Date signed (Month, Day, Year)

November 3, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Tower Box, JHH, 600 N. Wolfe St., Baltimore, MD 21287

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

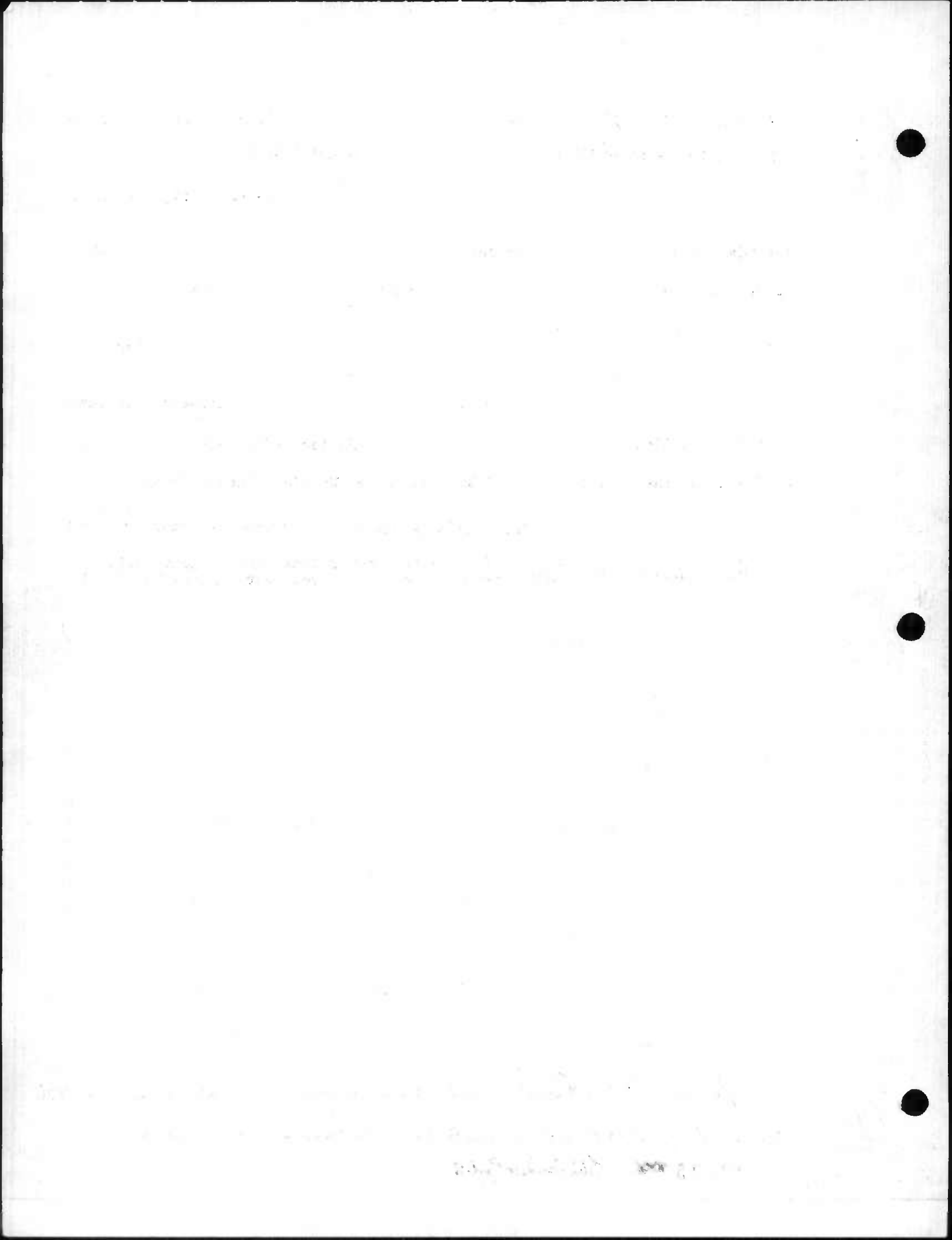
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34723

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Bernard Day

2. Date of Death

Month Day Year
NOVEMBER 4, 1996

3. Time of Death

9:34 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

None

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 4, 1996

9. Birthplace (State or Foreign Country)

usa

Usual Residence of Decedent

10a. State

Maryland

10b. County

P.G.

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11736 South Laurel Drive

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

X ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Fetus

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Ronald Day

18. Mother's Name (First, Middle, Maiden Surname)

Angie Walton

19a. Informant's Name/Relationship (Type, Print)

Angie Walton Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11736 South Laurel Dr. Laurel, Md. 20748

20a. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Park 11/7/96 Landover, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Dunn & Sons 5635 Eads St. NE DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. FETAL PREMATURITY

Due to (or as a consequence of):

10 minutes

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Premature Rupture of Membranes

at 22 weeks Gestational Age

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

X ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 46284

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY C. TYLER, MD 5480 Wisconsin Ave., #206, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34724

| | | | | | | | | | | |
|---|---|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GERALDINE DuBOSE | | | | 2. Date of Death
Month Day Year
NOV. 05, 1996 | | | | 3. Time of Death
11:01 AM | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES GENERAL HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
CHEVERLY | | | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
579-68-0429 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
59 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
SEPT. 26, 1937 | | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
N/A | 10b. County
N/A | 10c. City, Town or Location
WASHINGTON, D.C. | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
5515 HUNT PL. N.E. | | | | 10f. Zip Code
20019 | | 10g. Citizen of What Country?
UNITED STATES | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No N/A
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: N/A | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9TH Collegia (1-4or 5+) 9TH | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE (DOMESTIC) | | 16b. Kind of Business/Industry
PRIVATE | | | |
| | 17. Father's Name (First, Middle, Last)
ELISHA FOSKEY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HELEN MILLER FOSKEY | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
THOMASINA DuBOSE-EPPS/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13207 OLD STAGE COACH ROAD #2621
LAUREL, MARYLAND 20708 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HARMONY MEMORIAL CEM. NOV. 11, 1996 | | 20c. Location - City or Town, State
LANDOVER, MD | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Edward M. Dudley</i> | | | | 22. Name and Address of Facility
DUDLEY FUNERAL HOME
EDWARD M. DUDLEY 3200 R.I. AVE., MT. RAINIER, MD 20712 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a line.

Immediate Cause (Final disease or condition resulting in death)
e. Sudden cardiac death (arrhythmia)
Due to (or as a consequence of):
b. Hypertensive heart disease
Due to (or as a consequence of):
c. Chronic Hypertension
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate interval Between Onset and Death
—
5 years
35 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular disease
Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28t. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Michael Adams, MD</i> | | 29c. License number
21571 DC | | 29d. Date signed (Month, Day, Year)
11/7/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Adams, MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 08 1996 | | 32. Registrar's Signature
<i>Julia Anderson-Randall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
ExaminerState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34725

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE OLLIGAN DISHMAN

2. Date of Death
Month Day Year

OCTOBER 26 1996 1300

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

219-10-2636

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

April 15, 1912

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

100 Revolution Street Apt. 612

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

State Highway Dept.

17. Father's Name (First, Middle, Last)

Riley Dishman

18. Mother's Name (First, Middle, Maiden Surname)

Cordeillia Barker

19a. Informant's Name/Relationship (Type, Print)

Mrs. Martha A. Dishman (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 Revolution St., Apt. 612, Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens 10/30/96 Aberdeen, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Mary R. DiGiovanni

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD - Parkinson's ds - CVA
- Alzheimers - Peptic ulcer
- A. Fib - Peptic ulcer ds.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Biondo MD

29c. License number

542800

29d. Date signed (Month, Day, Year)

10/26/96

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)

J. Biondo MD, MCH. 3145 Union Ave, H&G, Md, 21078

31. Date filed (Month, Day, Year)

OCT 28 1996

32. Registrar's Signature

J. Biondo MD

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34726

8

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CARRIE VIRGINIA DIFFENDERFER | | | | 2. Date of Death
Month Day Year
OCTOBER 29 1996 | | 3. Time of Death
1800 | |
| | 4a. Facility Name (If not institution, give street and number)
Fallston General Hospital | | | | 4b. City, Town, or Location of Death
Fallston | | 4c. County of Death
HARFORD | |
| Funeral
Director | 5. Social Security Number
219-18-1390 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 18, 1910 | |
| | 9. Birthplace (State or Foreign Country)
West Virginia | | 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Edgewood | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
611 Wingleaf Ct. | | 10f. Zip Code
21040 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | | 16b. Kind of Business/Industry
Retail | | | |
| | 17. Father's Name (First, Middle, Last)
William Marion Price | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mattie Brooks Everly | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Dorothy C. Shriner - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
611 Wingleaf Ct., Edgewood, Md. 21040 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Hill Cemetery | | 20c. Date
10-31-96 | | 20d. Location - City or Town, State
Waynesboro, Pa. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Md. 21009 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. cerebral vascular accident
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
atrial fibrillation
dementia | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D 32299 | | 29d. Date signed (Month, Day, Year)
October 30, 1996 | |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID S. DUNN 615 W. MacPhail | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 1 1996 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is divided into two main sections: the first section deals with the general situation and the second section deals with the progress of the work.

2. The second part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work in the field and the second section deals with the results of the work in the laboratory.

3. The third part of the report deals with the conclusions of the work during the year. It is divided into two main sections: the first section deals with the conclusions of the work in the field and the second section deals with the conclusions of the work in the laboratory.

4. The fourth part of the report deals with the recommendations of the work during the year. It is divided into two main sections: the first section deals with the recommendations of the work in the field and the second section deals with the recommendations of the work in the laboratory.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34727

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL MCDANEL DAVIS

2. Date of Death

OCTOBER 22, 1996

3. Time of Death
9:30 pm

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

431- 18-3886

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 11, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

37 Homestead Street

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chemist

18b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Willie Cleveland Davis

18. Mother's Name (First, Middle, Maiden Surname)

Velma (mmm) Smith

19a. Informant's Name/Relationship (Type, Print)

Gladys M. Davis, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37 Homestead Street, Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel U.M. Church Cem. 10/26/96 Emmorton, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Stephen A. Hughes

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. INTRACRANIAL BLEED

Approximate Interval Between Onset and Death

~1/2 Hours

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. P. Edwards, M.D.

29c. License number

231775

29d. Date signed (Month, Day, Year)

OCTOBER 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. P. Edwards, M.D.

2702 BELAIR ROAD FALLSTON, MARYLAND 21047

31. Date filed (Month, Day, Year)

OCT 25 1996

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

96 34728

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELSIE DUNN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 27 1996 | | 3. TIME OF DEATH
5:55 PM | |
| 4. SOCIAL SECURITY NUMBER
214-09-9988 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
8/19/1904 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Meridian Nursing Center-Cromwell | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Parkville | | 9c. COUNTY OF DEATH
Baltimore | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Forest Hill | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1612 Denise Drive | | | | 10f. ZIP CODE
21050 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) — | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Waitress | | 16b. KIND OF BUSINESS/INDUSTRY
Restaurant | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Edward Ailstock | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rosa Etta Benson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Bettie L. Farmer/Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1532 Jarrettsville Rd. Jarrettsville, Md. 21084 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
Jarrettsville Cem. 10/30 | | 20c. LOCATION — City or Town, State
Jarrettsville, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
M. Bladden Kurtz | | | | 22. NAME AND ADDRESS OF FACILITY
Kurtz Funeral Home, P.A. Jarrettsville, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. Aspiration Pneumonia
b. Cerebrovascular Accident
c. Atherosclerotic Cardiovascular Disease
d. | | | | | | | Approximate Interval Between Onset and Death
2 DAYS
DAYS
YEARS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Fredric S. Sirkis M.D. | | | | 29c. LICENSE NUMBER
D22645 | | 29d. DATE SIGNED (Month, Day, Year)
10/28/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
FREDRIC S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 1 1996 | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | | | |

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the experiments carried out.

3. The third part is a discussion of the results obtained and their significance.

4. The fourth part is a conclusion drawn from the work done.

5. The fifth part is a list of references to the work of other authors.

6. The sixth part is a list of the names of the persons who have assisted in the work.

7. The seventh part is a list of the names of the persons who have read the report.

8. The eighth part is a list of the names of the persons who have approved the report.

9. The ninth part is a list of the names of the persons who have signed the report.

10. The tenth part is a list of the names of the persons who have read the report.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34729

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BLANCHE H. DICKSON | | | | 2. Date of Death
Month Day Year
Nov. 4, 1996 | | 3. Time of Death
8:45 am | |
| | 4a. Facility Name (If not institution, give street and number)
1320 Conowingo Road | | | | 4b. City, Town, or Location of Death
Bel Air | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
186-10-1622 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 14, 1904 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
MD | | 10b. County
Harford | | 10c. City, Town or Location
Bel Air | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
1320 Conowingo Road | | 10f. Zip Code
21014 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Florist | | 16b. Kind of Business/Industry
Retail | | | |
| | 17. Father's Name (First, Middle, Last)
Eck L. Hash | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary B. McKinnon | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Kenneth E. Tipton/Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2106 Churchville Road Bel Air, MD 21015 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Grove Cemetery | | 20c. Location - City or Town, State
11/7 Bel Air, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>Jeffrey P. Lovelidge</i> | | | | 22. Name and Address of Facility
Harkins Funeral Home, Inc., Delta, PA | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Respiratory Failure</i>
Due to (or as a consequence of):
b. <i>Chronic obstructive Pulmonary Disease</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Breast Carcinoma | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Mirza Baig</i> | | | | 29c. License number
D43115 | | 29d. Date signed (Month, Day, Year)
11/5/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mirza Baig, M.D. 622 S. Union Avenue Havre de Grace, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 6 1996 | | | | 32. Registrar's Signature
<i>John Randall</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34730

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH IRENE DOWNTON

2. Date of Death

Month

Day

Year

NOVEMBER

2,

1996

3. Time of Death

6:14 A.M.

4a. Facility Name (If not institution, give street and number)

56 GREEN STREET, TRAILER 7

4b. City, Town, or Location of Death

FROSTBURG

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

217 28 0122

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

NOV 29, 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

FROSTBURG

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

56 GREEN STREET, TRAILER 7

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married☒ Married☐ Widowed☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JAMES McKEE

18. Mother's Name (First, Middle, Maiden Surname)

ROSE THIELE

19a. Informant's Name/Relationship (Type, Print)

JACK DOWNTON / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

56 GREEN ST., TRAILER 7, FROSTBURG, MD 21532

20a. Method of Disposition

☐ Burial☒ Cremation☐ Removal from State☐ Donation☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

THE CUMBERLAND CREMATORY

Date

11/5/96

20c. Location - City or Town, State

CUMBERLAND, MD 21502

21. Signature of Funeral Service Licensee

Marilean M. Sowers

22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.

60 W. MAIN ST., FROSTBURG, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of):

b. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 hour

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marilean M. Sowers

29c. License number

D34846

29d. Date signed (Month, Day, Year)

11 NOVEMBER 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT J. ORLINO, M.D.

902 SETON DR. STE 202 CUMBERLAND, MD

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John H. Randall

State
Registrar

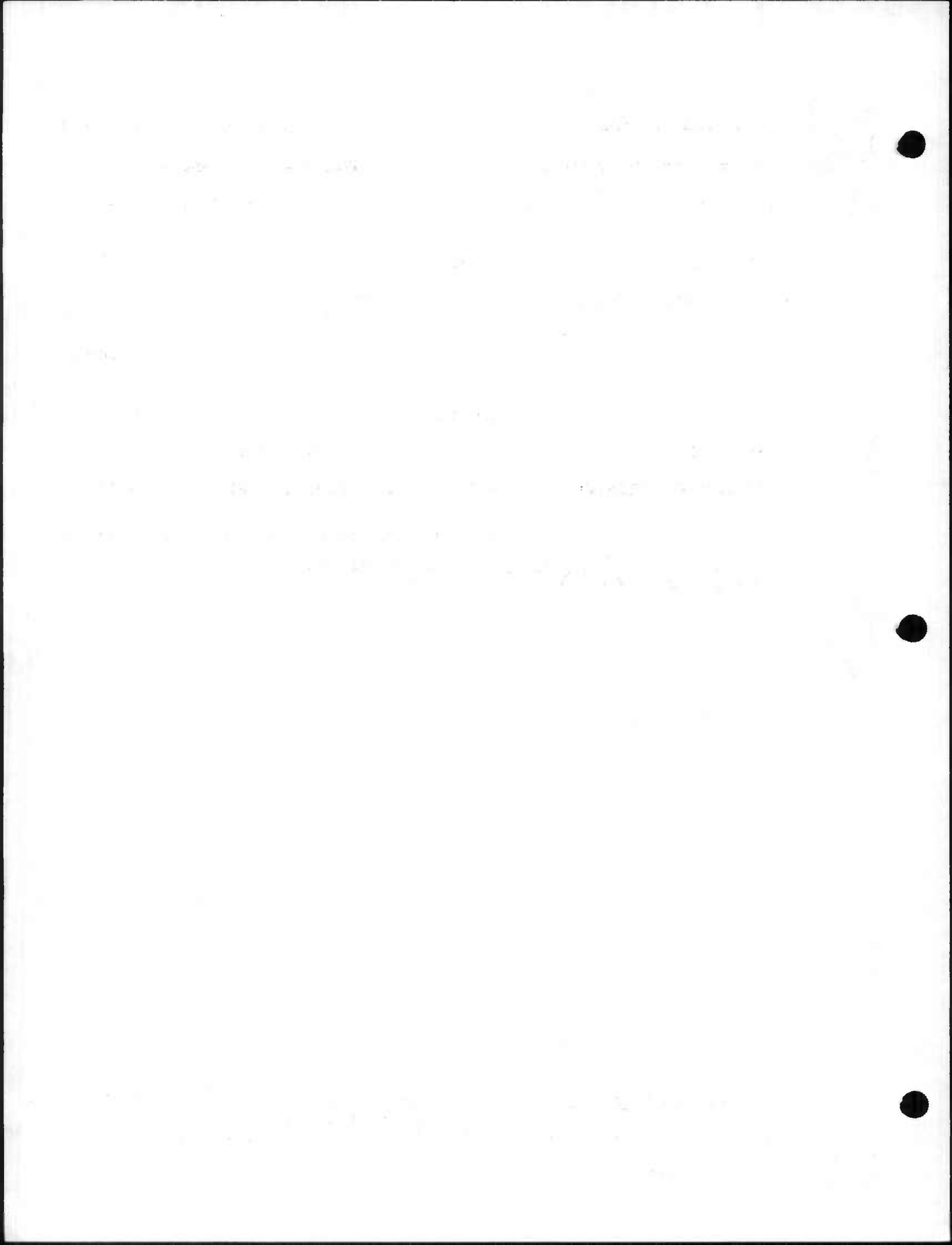
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34731

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|--|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES ARTHUR DEEM | | | | 2. Date of Death
Month OCTOBER Day 31 Year 1996 | | | | 3. Time of Death
11:10PM | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
218 60 1012 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
43 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT. 5, 1953 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | 10a. State
MARYLAND | | 10b. County
GARRETT | | 10c. City, Town or Location
FROSTBURG | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
234 S. CRANBERRY SWAMP DRIVE | | | | 10f. Zip Code
21532 | |
| | 10g. Citizen of What Country?
U.S. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 6/3/71 | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PRODUCE MANAGER | | | | 16b. Kind of Business/Industry
SUPER MARKET | | | | 17. Father's Name (First, Middle, Last)
CARROLL DEEM | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
JEAN JORDON | | | | 19. Informant's Name/Relationship (Type, Print)
ELIZABETH A. DEEM / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
234 S. CRANBERRY SWAMP DRIVE, FROSTBURG, MD 21532 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOLFE FAMILY CEMETERY | | | | 20c. Location - City or Town, State
11/3/96 FINZEL, MD | |
| | 21. Signature of Funeral Service Licensee
<i>Marilyn M. Sowers</i> | | | | 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A.
60 W. MAIN ST., FROSTBURG, MD 21532 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. metastatic colon carcinoma
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier
<i>Dr. Roy Chisholm</i> | | | | 29c. License number
D34362 | | | | 29d. Date signed (Month, Day, Year)
NOVEMBER 1, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. ROY CHISHOLM, 924 Seton Dr. Cumberland, MD 21532 | | | | 31. Date filed (Month, Day, Year)
NOV 03 1996 | | | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34732

| | | | | | | | | |
|---|--|--|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HARRY MORTON DEWITT, JR. | | | | 2. Date of Death
Month Oct Day 30 Year 1996 | | 3. Time of Death
7:51 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
424-05-8069 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 16, 1920 | 9. Birthplace (State or Foreign Country)
Alabama |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
11619 Gilsan Street | | | | 10f. Zip Code
20902 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944
If Yes, Give Year or Dates: to 1980 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Officer | | 16b. Kind of Business/Industry
U.S. Army | | |
| 17. Father's Name (First, Middle, Last)
Harry M. DeWitt, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lucille Wells | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Christine E. DeWitt | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11619 Gilsan Street, Silver Spring, Maryland 20902 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery | | 20c. Location - City or Town, State
Arlington, Virginia | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd. W. Silver Spring, MD 20901 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Respiratory failure
Due to (or as a consequence of):
b. Sepsis
Due to (or as a consequence of):
c. Pneumonia
Due to (or as a consequence of):
d. Stroke | | | | | | | | Approximate Interval Between Onset and Death
Days
Days
Days
Days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D-32332 | | 29d. Date signed (Month, Day, Year)
10/31/96 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
SK GUPTA, MD 9801 Georgia Ave, #220 Silver Spring Md 20902 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 9008.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34733

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred V. Davis

2. Date of Death

Month 10, Day 31, Year 1996

3. Time of Death

4:45 p.

4a. Facility Name (If not institution, give street and number)

5495 Cedar Lane

4b. City, Town, or Location of Death

Columbia

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

214-56-6835

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Mar. 24, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

5495 Cedar Lane

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Bendix Corp.

17. Father's Name (First, Middle, Last)

Willard B. Davis

18. Mother's Name (First, Middle, Maiden Surname)

Majoy Thomas

19a. Informant's Name/Relationship (Type, Print)

Shirley Harding (Foster Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13206 Highland Rd., Highland, MD 20777

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hopkins Church Cem. 11/5/96

Date

20c. Location - City or Town, State

Highland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Failure

5 days

Due to (or as a consequence of):

b. Breast cancer - metastatic stage IV C

4 years

Due to (or as a consequence of):

c. lung, chest wall, bone, liver mets.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia, Anorexia - Cachexia

Syndrome.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jon K. Minford

29c. License number

D 30573

29d. Date signed (Month, Day, Year)

11-1-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jon K. Minford, M.D. 11065 Little Patuxent Pkwy, Columbia, MD 21044

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34734

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jacob Lazarus Doniger

2. Date of Death

Month Day Year
October 30, 1996

3. Time of Death

9:15 PM

4a. Facility Name (If not institution, give street and number)

17219 Epsilon Place

4b. City, Town, or Location of Death

Derwood

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

055-16-9867

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

May 5, 1923

9. Birthplace (State or Foreign
Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

17219 Epsilon Place

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sports Broadcaster

16b. Kind of Business/Industry

Radio

17. Father's Name (First, Middle, Last)

Joseph Charles Doniger

18. Mother's Name (First, Middle, Maiden Surname)

Sophia Meisel

19a. Informant's Name/Relationship (Type, Print)

Elizabeth M. Doniger/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17219 Epsilon Place, Derwood, Maryland 20855

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

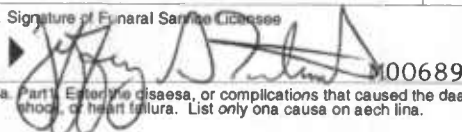
Montgomery Crematorium, Inc. Nov. 2, 1996

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

 000689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin
Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Severe Chronic Obstructive Pulmonary Disease

Approximate
Interval Between
Onset and Death

1 year

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Oat Cell Carcinoma of the Right Lung

Metachronous Carcinomas of the Cecum and Sigmoid Colon

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy
performed?

☐ Yes ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

☐ Yes ☐ No

25. Was case referred to medical
examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

28c. Injury at
Work?

☐ Yes ☒ No

28d. Describe how injury occurred

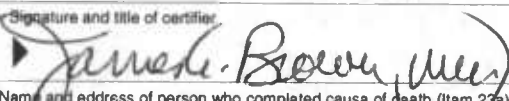
28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 07285

29d. Date signed (Month, Day, Year)

October 31, 1996

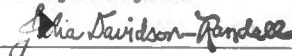
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James A. Brown, MD, 10605 Concord Street, #300, Kensington, Maryland 20895-2594

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature



State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner


To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

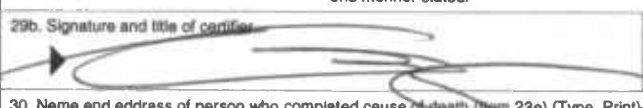

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 34735**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|--|---------------------------|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Vera M. Diggs | | | | | | 2. Date of Death
Month November Day 7 Year 1996 | | 3. Time of Death
9:07 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Montgomery General Hospital | | | | | | 4b. City, Town, or Location of Death
Olney | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
217-10-1902 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Days | 8. Date of Birth (Month, Day, Year)
August 12, 1915 | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
15107 Interlachen Drive #219 | | | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
United States | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Professor of Reading Comprehension | | | 16b. Kind of Business/Industry
College | | | |
| 17. Father's Name (First, Middle, Last)
Russell Mellott | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Olive Bussard | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dianna D. Landrum Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14600 Carrollton Road, Rockville, Maryland 20853 | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Location - City or Town, State
11-8-96 Beltsville, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Acute MI
Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease
Due to (or as a consequence of):</p> <p>c. _____
Due to (or as a consequence of):</p> <p>d. _____
Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>minutes</p> <p>Years</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD, Atrial Fibrillation, Obesity | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | 28d. Describe how Injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | | 29c. License number
D43202 | | 29d. Date signed (Month, Day, Year)
November 7, 1996 | |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)
C. Ozanne-Blankford, MD 3305 N. Leisure world Blvd Silver Spring, Maryland 20906 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 08 1996 | | | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 34736

DHHM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34737

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Ardena Ellison</i> | | | | 2. Date of Death
Month <i>November</i> Day <i>1</i> Year <i>1996</i> | | 3. Time of Death
<i>9:00 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Crofton Convalescent Center</i> | | | | 4b. City, Town, or Location of Death
<i>Crofton</i> | | 4c. County of Death
<i>Anne Arundel</i> | |
| Funeral
Director | 5. Social Security Number
<i>233 68 6843</i> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>83</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Sept. 5, 1913</i> | 9. Birthplace (State or Foreign Country)
<i>West Virginia</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>West Virginia</i> | | 10b. County
<i>Nicholas</i> | | 10c. City, Town or Location
<i>Craigsville</i> | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
<i>General Delivery Box 279</i> | | | | 10f. Zip Code
<i>26205</i> | | 10g. Citizen of What Country?
<i>United States</i> | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Own Home</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>Seymour Justice</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Della Riddle</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Loretta Borchers</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1669 Wilkshire Dr. Crofton Maryland 21114</i> | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>WV Memorial Gardens 11/4/96</i> | | 20c. Location - City or Town, State
<i>Calvin West Virginia</i> | | |
| 21. Signature of Funeral Service Licensee
<i>Robert E. Evans, Pres</i> | | | | 22. Name and Address of Facility
<i>Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Maryland 20715</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Pneumonia</i>
Due to (or as a consequence of):
<i>Alcoholism</i>
Due to (or as a consequence of):
<i>Cholelithiasis left leg</i>
Due to (or as a consequence of):
<i>Malnutrition/Dehydration</i>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Dysphasia
Dysphagia</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Carole Prosser</i> | | 29c. License number
<i>D25134</i> | | 29d. Date signed (Month, Day, Year)
<i>11/1/96</i> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>CAROL PROSSER, MD 1655 Crofton Blvd. Crofton Md.</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>NOV 05 1996</i> | | | | 32. Registrar's Signature
<i>Jahk Arundel-Randall</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34738

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
INA ESTELLE ENGLAND | | | | 2. Date of Death
Month Day Year
November 4, 1996 | | 3. Time of Death
10:31 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
608 Lake Avenue | | | | 4b. City, Town, or Location of Death
Edgewood | | 4c. County of Death
Harford | | |
| Funeral
Director | 5. Social Security Number
413-18-1374 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
July 7, 1914 | 9. Birthplace (State or Foreign Country)
Tennessee | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Edgewood | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
608 Lake Avenue | | | | 10f. Zip Code
21040 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Waitress | | | 16b. Kind of Business/Industry
Restaurant | | |
| | 17. Father's Name (First, Middle, Last)
James Martin Selby | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Francis Null | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Jimmie D. Scott, daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
608 Lake Avenue, Edgewood, Maryland 21040 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Memorial Gardens Association | | Date
11/8/96 | | 20c. Location - City or Town, State
Mt. Pleasant, MI | | |
| | 21. Signature of Funeral Service Licensee
Hilly K. McComas | | | | 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Orthostatic hypotension, UTI | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
D. L. Pirovolidis MD | | | | 29c. License number
D09574 | | 29d. Date signed (Month, Day, Year)
11/5/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D.L. Pirovolidis, MD 104 Plumtree Rd-Suite 115 Bel Air, Md 21014 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 6 1996 | | | | 32. Registrar's Signature
John Randall | | | | | |

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting cycle, from identifying the transaction to posting it to the appropriate ledger account.

3. The third part of the document discusses the role of the auditor in verifying the accuracy of the records. It explains how the auditor uses various techniques, such as sampling and vouching, to ensure that the financial statements are true and fair.

4. The fourth part of the document discusses the importance of internal controls in preventing errors and fraud. It describes the various types of internal controls, such as segregation of duties and authorization, and how they are implemented in an organization.

5. The fifth part of the document discusses the role of the management in ensuring the accuracy of the financial statements. It explains how management is responsible for the overall integrity of the financial system and for the accuracy of the information provided to the shareholders.

96 34739

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
LEONARD EPISCOPIA | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOVEMBER 1, 1996 | | 3. TIME OF DEATH
3:25 PM | |
| 4. SOCIAL SECURITY NUMBER
113-28-9125 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
91 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 12, 1905 | | 8. BIRTHPLACE (State or Foreign Country)
New York | |
| 9a. FACILITY NAME (If not institution, give street and number)
Villa Rosa Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Mitchellville | | 9c. COUNTY OF DEATH
Prince Georges | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Greenbelt | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
108 Tamarisk Court | | 10f. ZIP CODE
20770 | |
| 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | 11. MARITAL STATUS
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
5 Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Self-employed | | 16b. KIND OF BUSINESS/INDUSTRY
Waste Removal | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Episcopia | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rose Morando | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Rosemarie Mangialardi/Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
108 Tamarisk Court, Greenbelt, Maryland 20770 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 11/5 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Alzheimer's type dementia
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
Days 7 |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD CHF | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D32261 | | 29d. DATE SIGNED (Month, Day, Year)
11-1-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard Feldman 9500 Annapolis Rd. Landover 20706 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 07 1996 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

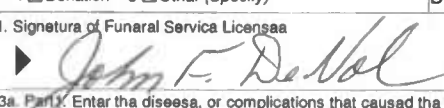
State of Maryland / Department of Health and Mental Hygiene

96 34740

Certificate of Death

Reg. No.

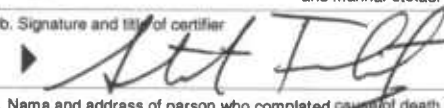
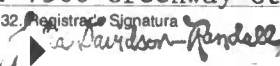
Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
Eva Gay Ehrmantraut | | | | 2. Date of Death
Month Oct. Day 28, Year 1996 | | 3. Time of Death
3:35 Am | |
| 4a. Facility Name (If not institution, give street and number)
Greenbelt Nursing & Rehab. Home | | | | 4b. City, Town, or Location of Death
Greenbelt | | 4c. County of Death
Prince George | |
| 5. Social Security Number
234-38-9652 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 1, 1923 | 9. Birthplace (State or Foreign Country)
West Virginia |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
Prince George | | 10c. City, Town or Location
Greenbelt | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
7010 Greenbelt Rd. | | | | 10f. Zip Code
20770 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
sales clerk | | 16b. Kind of Business/Industry
sales | |
| 17. Father's Name (First, Middle, Last)
Lester M. Foltz | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hannah Catherine Keller | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret A. Allison/niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7710 Old. Muirkirk Rd., Beltsville, Md. 20705 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Southern Memorial Gardens | | Date
Oct. 31, 96 | | 20c. Location - City or Town, State
Dunkirk, Md. | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
DeVol Funeral Home
2222 Wisconsin Ave., NW Wash., D.C. 20007 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia
Due to (or as a consequence of):

b. Impaired Gag Reflex
Due to (or as a consequence of):

c. Dementia
Due to (or as a consequence of):

d. | | | | | | | |
| Approximate Interval Between Onset and Death
2 months
2 months
Years | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia with Flexion Contractures | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D31001 | | 29d. Date signed (Month, Day, Year)
Nov. 5, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stuart Turkewitz, M.D. 7500 Greenway Ctr. Drive #430 Greenbelt, Md. 20770 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

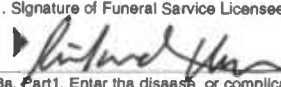
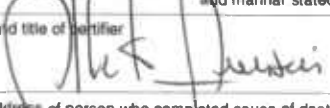
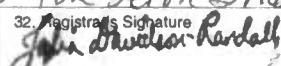
159

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34741

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|-------------------------------|---|---|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HARRISON ISLES FULLER | | | | | | 2. Date of Death
Month Day Year
NOVEMBER 12 1996 | | 3. Time of Death
9:40 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegheny | | |
| Funeral
Director | 5. Social Security Number
220-10-4834 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 | | 8. Date of Birth (Month, Day, Year)
4-3-14 | | 9. Birthplace (State or Foreign Country)
Keyser, WV | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
WV | | 10b. County
Mineral | | 10c. City, Town or Location
Keyser | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
630 Chestnut St. | | | | 10f. Zip Code
26726 | | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Insurance | | | | 16b. Kind of Business/Industry
Insurance | | | |
| 17. Father's Name (First, Middle, Last)
James Ray Fuller | | | | | | 18. Mother's Name (First, Middle, Maiden Sumama)
Bessie L. Kesecker Fuller | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Harrison Fuller Donor File | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WVU-HGR | | Date
11-12-96 | | 20c. Location - City or Town, State
Morgantown, WV | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
WVU-Human Gift Registry
P. O. Box 9131, Morgantown, WV 26506-9131 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy. Ischemic | | | | | | | | | | 7 days | |
| Due to (or as a consequence of):
b. Arteriosclerosis | | | | | | | | | | | |
| Due to (or as a consequence of):
c. | | | | | | | | | | | |
| Due to (or as a consequence of):
d. | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Duodenal ulcer, bleeding.
Arterial embolisms | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier
 | | 29c. License number
D23167 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 12, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Juan A. Arisueno, M.D. 902 Seton Drive Cumberland, MD 21502. | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34742

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JANICE

DENISE

FOX

2. Date of Death
Month Day Year

NOVEMBER 4, 1996

3. Time of Death

1339PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

577-68-4609

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Nov. 11, 1951

9. Birthplace (State or Foreign Country)

Dist. of Colum.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2830 Iverson Street

10f. Zip Code

20748

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Unit Secretary

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

James Fox

18. Mother's Name (First, Middle, Maiden Surname)

Juanita Mabel Wood

19a. Informant's Name/Relationship (Type, Print)

Juanita Fox (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8812 Lanier Dr., Silver Spring, Md 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park 11/9/96 Landover, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

L. W. Plunkett Funeral Home
2504 - 28th ST., NE., Washington, D.C. 20018-1413

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Subarachnoid Hemorrhage*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

NOVEMBER 05, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODOR M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34743
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDWIN H. FRIEDMAN | | | | | | 2. Date of Death
Month Day Year
OCTOBER 31, 1996 | | 3. Time of Death
7:08p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
6 WYNKOOP COURT | | | | | | 4b. City, Town, or Location of Death
BETHESDA | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
130-24-8400 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 64 | | 8. Date of Birth (Month, Day, Year)
MAY 17, 1932 | | 9. Birthplace (State or Foreign Country)
NEW YORK | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | | 10b. County
MONTGOMERY | | | 10c. City, Town or Location
BETHESDA | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
6 WYNKOOP COURT | | | | | | 10f. Zip Code
20817 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | | | | | 15e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FAMILY THERAPIST | | | 15b. Kind of Business/Industry
FAMILY THERAPY | |
| 17. Father's Name (First, Middle, Last)
HENRY FRIEDMAN | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LILLIAN FRIEDMAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CARLYN FRIEDMAN (WIFE) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 WYNKOOP COURT BETHESDA, MARYLAND 20817 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
JUDEAN MEMORIAL GARDENS | | Date
11/3/96 | | 20c. Location - City or Town, State
OLNEY, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic coronary disease
Due to (or as a consequence of):

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | 29c. License number
D34032 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 1, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. JEANNE P. ASHER, 3720 FARRAGUT AVE., KENSINGTON, MARYLAND 20895-2110 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34744

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ellen, Lynn, Forbes

2. Date of Death

Month Day Year

10

31

96

1:20 PM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

219 56 4780

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

0 21

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10/10/1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Selbyville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

322 Shady Park

10f. Zip Code

19975

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Special Education Teacher

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Arlie R. Mansberger

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Piel

19a. Informant's Name/Relationship (Type, Print)

Arlie R. Mansberger/ Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 7th Street Augusta, GA 30901

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Westover Memorial Park Nov. 4, 1996 Augusta, GA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home, Inc.
254 Carroll St. NW Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Liver Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alcoholic Hepatitis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

P10 221

29d. Date signed (Month, Day, Year)

10/31/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES WANG, University of Maryland Baltimore, MD

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

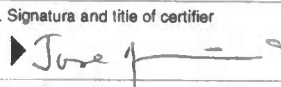
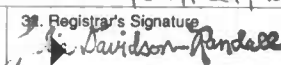
Certificate of Death

Reg. No.

96 34745

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
AMANDA FORBES | | | | 2. Date of Death
Month Day Year
OCTOBER 29, 1996 | | 3. Time of Death
1:17 PM | |
| 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death | |
| 5. Social Security Number
230-32-0733 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 28, 1920 | |
| 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1209 Magnolia Road | | 10f. Zip Code
20905 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Genealogist | | 16b. Kind of Business/Industry
Genealogy | | 17. Father's Name (First, Middle, Last)
John Edwin Arbogast | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Crawford Gilkeson | | 19a. Informant's Name/Relationship (Type, Print)
John A. Forbes, Sr. - Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1209 Magnolia Road, Silver Spring, Maryland 20905 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Monterey Cemetery | | 20c. Location - City or Town, State
11-2-96 Monterey, Virginia | | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Ave., Silver Spring, MD 20904 | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | e. CEREBRAL HERNIATION
Due to (or as a consequence of): | | | | 5 DAYS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. CEREBRAL INFARCTIONS
Due to (or as a consequence of): | | | | 11 DAYS | |
| | | c. VASOSPASM AFTER ANEURYSM SURGERY
Due to (or as a consequence of): | | | | 11 DAYS | |
| | | d. | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier

Neurology Post-doctoral fellow | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
OCTOBER 29, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jose I. Suarez, 600 North Wolfe Street, Baltimore, Maryland 21287 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

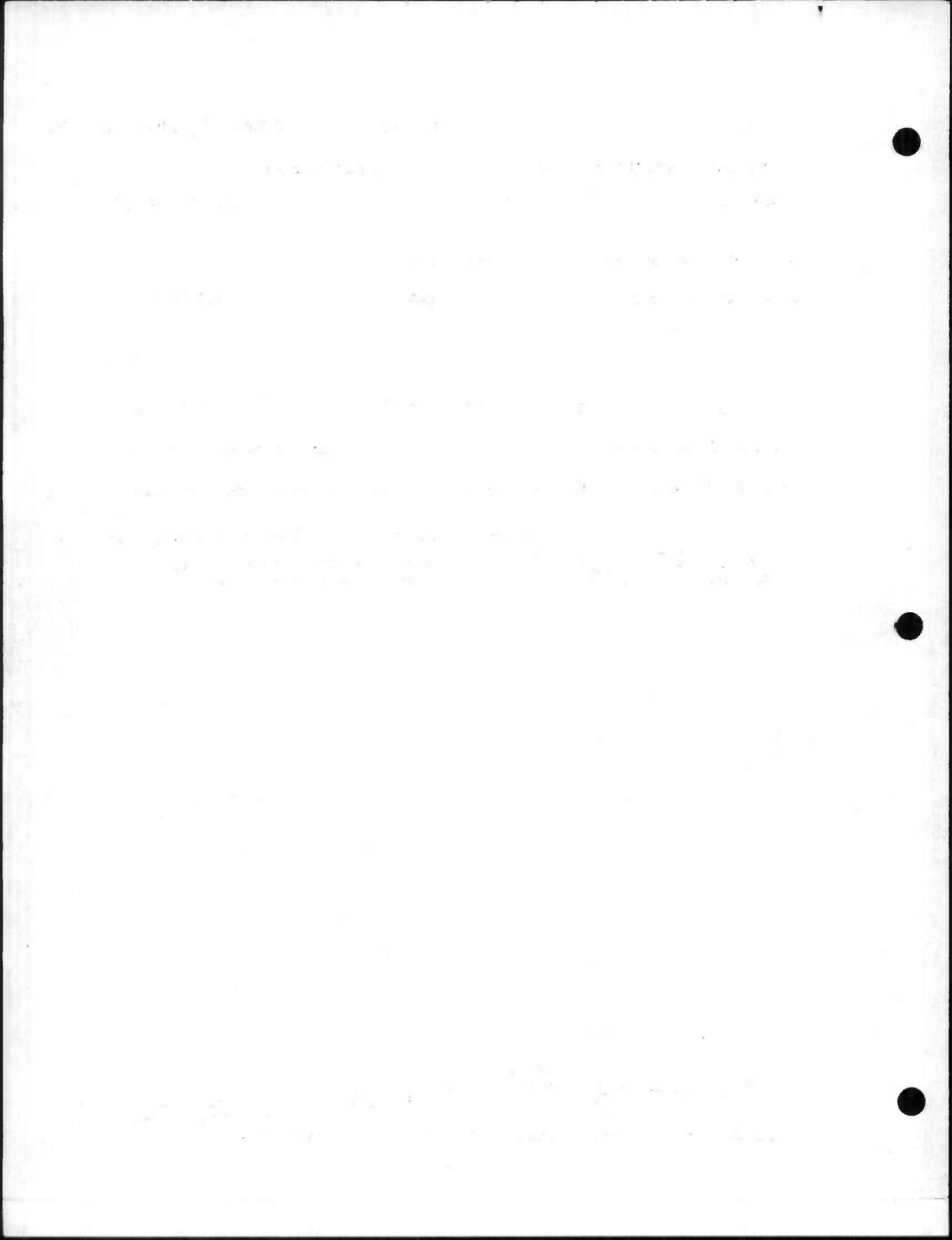
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34746

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Webster GARRISON

2. Date of Death

Month Day Year
November 14, 1996

3. Time of Death

1:30 AM

4a. Facility Name (If not institution, give street and number)

College View Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

230-34-3102

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DEC. 3, 1906

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

OLNEY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3517 CHERRY VALLEY DRIVE

10f. Zip Code

20832

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

0

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

FARM

17. Father's Name (First, Middle, Last)

SAMUEL GARRISON

18. Mother's Name (First, Middle, Maiden Surname)

MARY JANE GARRISON

19a. Informant's Name/Relationship (Type, Print)

KENNETH E. GARRISON, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5225 POOKS HILL ROAD, BETHESDA, MD. 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SALEM CEMETERY

Date

11/16/96

20c. Location - City or Town, State

BROOKEVILLE, MD.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Coronary Artery Disease

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Allen J. Gilson

29c. License number

D 26516

29d. Date signed (Month, Day, Year)

November 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Allen J. Gilson, MD, 1475 Taney Avenue, Frederick, Maryland 21702

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar's Signature

John A. Harrison-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34747

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kamara Renee Grant | | | | | | 2. Date of Death
Month: 10 Day: 19 Year: 96 | | 3. Time of Death
3:25 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
N/A | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. | | 8. Date of Birth (Month, Day, Year)
2 5 10-19-96 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Landover | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
2366 Vermont Avenue #101 | | | | 10f. Zip Code
20785 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | | 16b. Kind of Business/Industry
N/A | | |
| | 17. Father's Name (First, Middle, Last)
Keith Grant | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lavonda Dunn-Williams | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Lavonda Dunn-Williams/Mother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2366 Vermont Avenue #101, Landover MD 20785 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Location - City or Town, State
Landover, Maryland | | 20d. Date
11/2/96 | |
| | 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
J. B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785 | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. EXTREME PREMATUREITY
Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed?
undecided
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MULTIPLE CONGENITAL ANOMALIES
Genu Recurvatum Left
Bilateral Club Feet - Equinovarus
Redundant Neck Skin abnormality | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Cynthia K Ewing M.D. (EWING) | | 29c. License number
D51110 | | 29d. Date signed (Month, Day, Year)
10/19/96 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CYNTHIA K EWING, HOLY CROSS HOSPITAL, NEONATAL UNIT, SILVER SPRING, MD | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | | | 32. Registrar's Signature
John R. Ricketts | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34748

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kya Regene Grant

2. Date of Death

Oct 28 1996 Year

3. Time of Death

8:01 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

9

8. Date of Birth

(Month, Day, Year)

10-19-96

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2366 Vermont Avenue #101

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Keith Grant

18. Mother's Name (First, Middle, Maiden Summa)

Lavonda Dunn-Williams

19a. Informant's Name/Relationship (Type, Print)

Lavonda Dunn-Williams/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2366 Vermont Ave. #101, Landover MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial Park

Date

11/2/96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardio-respiratory failure

Due to (or as a consequence of):

40 minutes

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Extreme immaturity

Due to (or as a consequence of):

10 days

c. Left Cerebellar Hemorrhage

Due to (or as a consequence of):

unknown

d. Group B Streptococcal sepsis

10 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Distress syndrome

Anemia

Apnea of Prematurity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

N/A

28b. Time of

Injury

N/A

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

N/A

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

N/A

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Matthew B. Read, MD Attending Physician

29c. License number

00050522

29d. Date signed (Month, Day, Year)

10/31/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Holy Cross Hospital, 1500 Forest Glen Road, Silver Spring, MD

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson Randall

State
RegistrarBaltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34749

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN ESE GARNER

2. Date of Death

October 27 1996 5:25 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

246-30-9890

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 17, 1928

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9001 Cherry Lane

10f. Zip Code

20708

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th grade

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

John Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Letha Davis

19a. Informant's Name/Relationship (Type, Print)

Tonya Roberson (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

221 33rd Street, N.E. Washington, D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland National Park

Date

11/2/96

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rollins Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ISCHEMIC BOWEL

Due to (or as a consequence of):

2 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ATHEROSCLEROSIS

Due to (or as a consequence of):

7 DAYS

c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UPPER GASTROINTESTINAL BLEED

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25422

29d. Date signed (Month, Day, Year)

OCTOBER 28, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. MACKIN, MD

LAUREL, MD 20708

State
Registrar

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

John Anderson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34750

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERNICE G. GOODWIN

2. Date of Death

Month Day Year
NOVEMBER 4, 1996

3. Time of Death

1500

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-12-9329

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 15, 1915

9. Birthplace (State or Foreign Country)

Pomomkey, MD

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

District of Columbia

Washington

10e. Street and Number

4413 3rd Street, N. W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Correspondence Clerk

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Bernard Gray

18. Mother's Name (First, Middle, Maiden Surname)

Irene Fenwick

19a. Informant's Name/Relationship (Type, Print)

Claudia J. Butler - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8477 Greenbelt Road, Greenbelt, Maryland 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

11/9/96

20c. Location - City or Town, State

Washington, D. C.

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Carcinomatosis

Due to (or as a consequence of):

b.

Suspected Gastric Carcinoma

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcoholic Liver Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jose F. Bonelli MD

29c. License number

D 35055

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jose F. Bonelli, MD 8807 Colesville Rd 5th Fl., Silver Spring Md 20910

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

John Anderson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1911

1911

1911

1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34751

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE ELEANOR BRAMBLE

2. Date of Death

October 26 96 11:35 P

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Lorien Riverside Nursing & Rehab. Center

4b. City, Town, or Location of Death

BELCAMP

4c. County of Death

HARFORD

5. Social Security Number

212-36-1386

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 8, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3122 James Run Rd.

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Morris Oliver Penn

18. Mother's Name (First, Middle, Maiden Surname)

Louisa (nmn) Vondewettern

19a. Informant's Name/Relationship (Type, Print)

Betty Johnson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3122 James Run Rd., Aberdeen, MD 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Providence Cemetery

Date

10-29-96

20c. Location - City or Town, State

Glenelg, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Md. 2100923a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D28339

29d. Date signed (Month, Day, Year)

October 28 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA FICKEL 1015 Wheel Road Bel Air MD 21011

31. Date filed (Month, Day, Year)

OCT 29 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34752

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Harold Edgar Grinnell | | | | 2. Date of Death
Month Day Year
November 5, 1996 | | 3. Time of Death
1:10 am | | |
| | 4a. Facility Name (If not institution, give street and number)
Bel Forest Nursing & Rehab. Center | | | | 4b. City, Town, or Location of Death
Forest Hill | | 4c. County of Death
Harford | | |
| Funeral
Director | 5. Social Security Number
229-24-1621 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 70 | | 8. Date of Birth (Month, Day, Year)
01-07-1926 | | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Md. | | 10b. County
Harford | | 10c. City, Town or Location
White Hall (Norrisville) | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
3127 Green Road | | 10f. Zip Code
21161 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Caucasian | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Lumber | | 17. Father's Name (First, Middle, Last)
Henry Alonzo Grinnell | | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Ann Kathaleen Gilman | | 19a. Informant's Name/Relationship (Type, Print)
Carol L. Hastings/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as #10 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Mem. Gardens 11/7 | | 20c. Location - City or Town, State
Aberdeen, Maryland | | 21. Signature of Funeral Service Licensee
M. Gladsten Kurtz | | 22. Name and Address of Facility
Kurtz Funeral Home, P.A.
Jarrettsville, Maryland | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Malignant Melanoma
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
18 months | | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of causa of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| State Registrar | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| | 29b. Signature and title of certifier
Mark Wild | | 29c. License number
d35522 | | 29d. Date signed (Month, Day, Year)
November 5, 1996 | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
Mark Wild 2 North Avenue Bel Air Maryland 21014 | | |
| 31. Date filed (Month, Day, Year)
NOV 8 1996 | | 32. Registrar's Signature
John Andrew Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Amended # 20c, 11/6/96, N.D.S., Allegany County

96 34753

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RUTH VIOLA GREEN | | | | 2. DATE OF DEATH
MONTH 11 DAY 2 YEAR 96 | | 3. TIME OF DEATH
5:15 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER
212-32-8206 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 11, 1917 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Egle Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lonaconing | | | 9c. COUNTY OF DEATH
Allegany | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Frostburg | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
59 Bowery Street | | | | 10f. ZIP CODE
21532 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Clothing | | | 16b. KIND OF BUSINESS/INDUSTRY
Shirt | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Merton Ravenscroft | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Cordelia Robeson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Austin Green | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Avilton Lonaconing Rd, Lonaconing, Md. 21539 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Green Family Cem. Nov. 6, 1996 Lonaconing, Md. | | | 20c. LOCATION — City or Town, State | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jan E. Mule</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Eichhorn-McKenzie Funeral Home
Lonaconing, Md. 21539 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Carcinoma Lung with metastases</u>
DUE TO (OR AS A CONSEQUENCE OF):
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death
7 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cardiac arrhythmia
Hypertension | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>James J. M.D.</i> | | | | 29c. LICENSE NUMBER
007004 | | 29d. DATE SIGNED (Month, Day, Year)
11/4/96 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
L.R. MILES, JR., M.D. 57 JACKSON ST. LONACONING MD 21539 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 06 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Duckson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

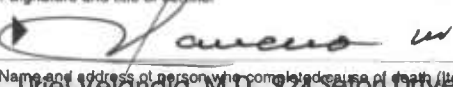
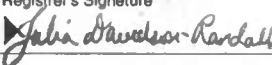
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34754

| | | | | | | | |
|---|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William W. Gordon | | | 2. Date of Death
Month October Day 31 Year 1996 | | 3. Time of Death
6:30 PM | |
| | 4e. Facility Name (If not institution, give street and number)
15214 Mount Savage Road, N.W. | | | 4b. City, Town, or Location of Death
Mount Savage | | 4c. County of Death
Allegany | |
| Funeral
Director | 5. Social Security Number
214-01-0146 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
28-Apr-13 |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Allegany | | 10c. City, Town or Location
Mount Savage |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
15214 Mount Savage Road, N.W. | | 10f. Zip Code
21545 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Drilling Operator | | 16b. Kind of Business/Industry
Well Drilling | | |
| | 17. Father's Name (First, Middle, Last)
Abram Gordon | | 18. Mother's Name (First, Middle, Maiden Surname)
Cecelia Hosken | | 19a. Informant's Name/Relationship (Type, Print)
Jessie Gordon Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15214 Mt. Savage Rd., N.W. Mount Savage Maryland 21545 |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Frostburg Memorial Park | | 20c. Location - City or Town, State
03-Nov-96 Frostburg, Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
C.H.F. & edema 20 to 37 years
Due to (or as a consequence of):
Dilated Cardiomyopathy 37 years
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
D.M. M.I.D. 20 years
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier
 | | 29c. License number
DO 8377 | | 29d. Date signed (Month, Day, Year)
11-4-96 | | | |
| 30. Name and address of person who completed cause of death (Item 30a) (Type, Print)
John Velandia, M.D., 724 Seron Drive, Cumberland, Maryland 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the results, and the conclusions drawn from the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the theoretical and practical implications of the findings, and the suggestions for further research.

5. The fifth part of the report is a conclusion. It summarizes the main findings of the study and the overall conclusions drawn from the research.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.

8. The eighth part of the report is a glossary. It includes a list of the terms and symbols used in the study, and their definitions.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34755

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Matthew Joseph Gibney, Jr.

2. Date of Death

November 3, 1996

3. Time of Death

9:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

20412 Oak Bluff Drive

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

579-16-1641

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 19, 1912

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20412 Oak Bluff Drive

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No WWII
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Economics Professor

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Matthew Joseph Gibney, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Gertrude Arnold

19a. Informant's Name/Relationship (Type, Print)

Jessie Rue Gibney, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20412 Oak Bluff Drive, Gaithersburg, MD 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gethsemane Cemetery

Date

Nov. 7, 1996

20c. Location - City or Town, State

Reading, Pennsylvania

21. Signature of Funeral Service Licensee

Michael D. Gibbons

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Dr., Gaithersburg, MD 20877

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ruptured Abdominal Aortic Aneurysm

Due to (or as a consequence of):

b. Arteriosclerotic Vascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Cirrhosis

Acute Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

Michael D. Gibbons

29c. License number

D35192

29d. Date signed (Month, Day, Year)

November 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin M. Gil, M.D., 15001 Dufief Mill Rd, Gaithersburg, MD 20878

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

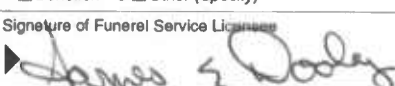
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

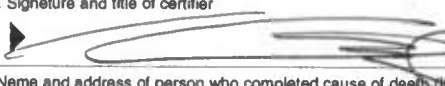

State of Maryland / Department of Health and Mental Hygiene

96 34756

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eileen Nettie Getz | | | | 2. Date of Death
Month Day Year
November 4, 1996 | | 3. Time of Death
6:07 PM | |
| | 4e. Facility Name (If not institution, give street and number)
Montgomery General Hospital | | | | 4b. City, Town, or Location of Death
Olney | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
577-42-9144 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 25, 1919 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10e. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | |
| 17. Father's Name (First, Middle, Last)
Edgar Lee Liday | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mabel Mary Fry | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Betty G. Windsor | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4504 Adrian Street Rockville, Maryland 20853 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 11/7/96 Silver Spring, Maryland | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W. Silver Spring, MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)
e. Intracerebral bleed, massive
Due to (or as a consequence of):</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death
hours</p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D43202 | | 29d. Date signed (Month, Day, Year)
November 5, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. Ozanne-Blankard, MD 3305 North Leisure World Blvd Silver Spring, Maryland 20906 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

9

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34757

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE LOUISE Glumac

2. Date of Death

Month

Day

Year

NOV. 4 1996

3. Time of Death

5:35 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-16-0165

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 31, 1921

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4911 Donovan Place

10f. Zip Code

20781

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert C. Raley

18. Mother's Name (First, Middle, Maiden Surname)

Eva G. Tippet

19a. Informant's Name/Relationship (Type, Print)

Michael J. Glumac, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4911 Donovan Place Hyattsville, Maryland 20781

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery

Date

11/07/96

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial fibrillation
Urinary tract Infection
Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15146

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

354 University Blvd - W. Silver Spring, Md. 20901

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34758

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN M. GUTTERMAN

2. Date of Death
Month Day Year

NOVEMBER 2, 1996

3. Time of Death
0240

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

119-07-0475

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Jan. 13, 1919

9. Birthplace (State or Foreign
Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12810 Evanston Street

10f. Zip Code

20853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ NoIf Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Chief of Food Standards

16b. Kind of Business/Industry

United States
Government

17. Father's Name (First, Middle, Last)

Abraham Joseph Gutterman

18. Mother's Name (First, Middle, Maiden Surname)

Clara Ethel Elkes

19a. Informant's Name/Relationship (Type, Print)

Sharon Press/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4516 Mt. Olney Lane, Olney, MD 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Judean Memorial Gardens

Date

11/03

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. STROKE
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Diabetes
Due to (or as a consequence of):

20 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal failure
Prostate Cancer

23b. Did tobacco use contribute to the causes of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3941 FERRARA WHEATON MD 20906

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

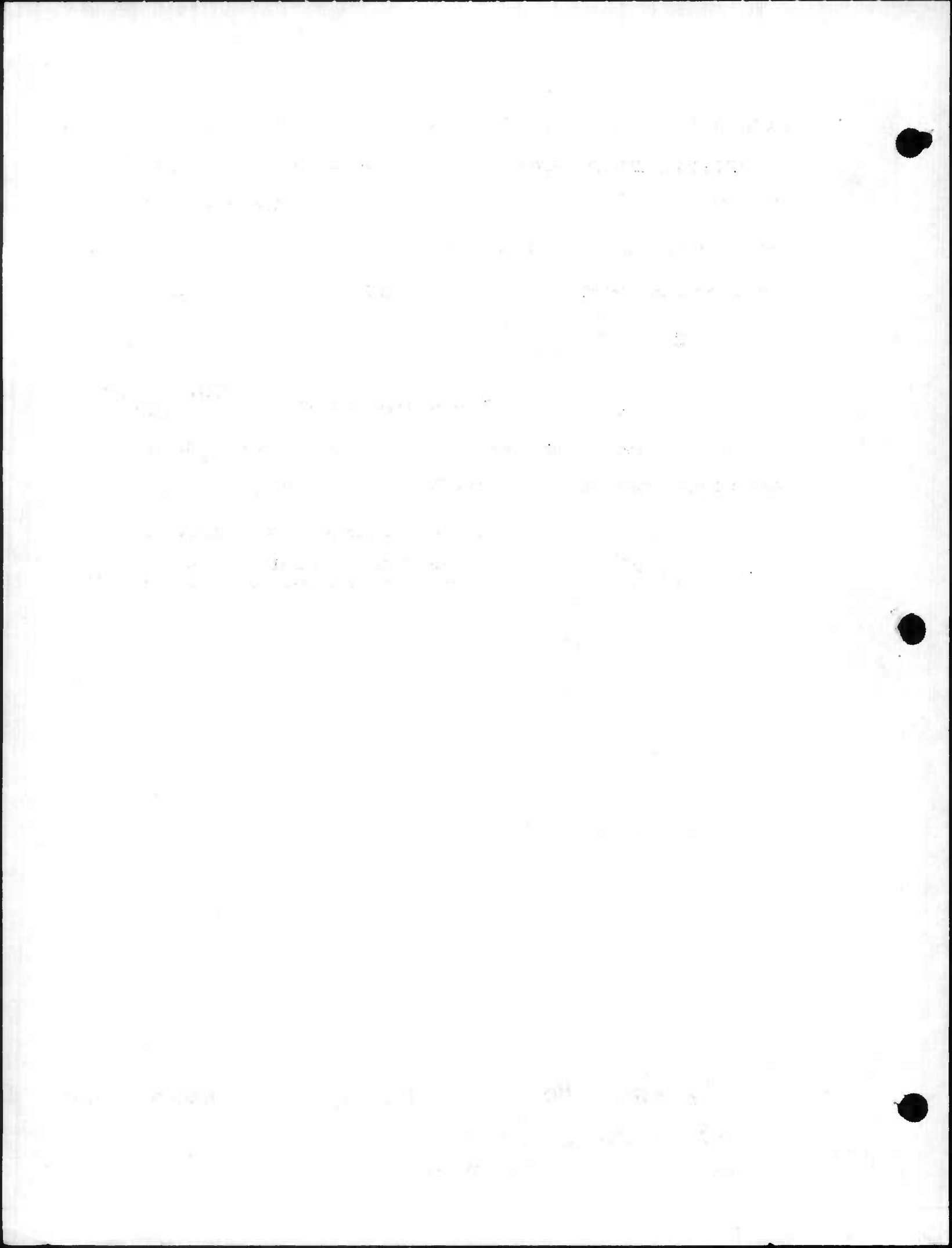
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 24a, PER DR. FILM G-741

State of Maryland / Department of Health and Mental Hygiene

96 34759

11/19/96 t.t

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Maney Harrison</i> | | | | 2. Date of Death
Month <i>October</i> Day <i>26</i> Year <i>1996</i> | | | | 3. Time of Death
<i>2344</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>University of Maryland Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>222-30-8118</i> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>55</i> Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Days | 8. Date of Birth
(Month, Day, Year)
<i>01-28-41</i> | 9. Birthplace (State or Foreign Country)
<i>Georgia</i> | | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>South Carolina</i> | | 10b. County
<i>Lexington</i> | | 10c. City, Town or Location
<i>West Columbia</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
<i>600 Ermine Rd.</i> | | | | 10f. Zip Code
<i>29169</i> | | 10g. Citizen of What Country?
<i>US</i> | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>white</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>3</i> College (1-4or 5+) <i></i> | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Paving</i> | | | 16b. Kind of Business/Industry
<i>Road Repair</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Pete Harrison</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Posie Harrison</i> | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Linda Harrison - wife</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>600 Ermine Rd., West Columbia, SC 29169</i> | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Pine View Mem. Garden</i> | | Date
<i>10/29/96</i> | | 20c. Location - City or Town, State
<i>North Augusta, Georgia</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>John A. Cranston</i> | | 22. Name and Address of Facility
<i>CRANSTON FUNERAL HOME</i>
<i>P.O. Box 967, Seaford, De. 19973</i> | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<i>a. Probable Atherosclerotic Heart Disease</i>
Due to (or as a consequence of):

<i>b.</i> Due to (or as a consequence of):

<i>c.</i> Due to (or as a consequence of):

<i>d.</i> | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
<i>Jonathan Stuart Olshaker MD</i> | | | | 29c. License number
<i>038437</i> | | | | 29d. Date signed (Month, Day, Year)
<i>October 26, 1996</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Jonathan Stuart Olshaker 22 South Greene Street, Baltimore, Maryland</i> | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
<i>NOV 19 1996</i> | | | | 32. Registrar's Signature
<i>John Davidson Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34760

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALICE BELLE WRIGHTSON HADDAWAY | | | | 2. Date of Death
Month Day Year
Nov. 2 1996 | | 3. Time of Death
9:50 p | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
212-28-4037 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 17, 1905 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Talbot | | 10c. City, Town or Location
Sherwood | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
21907 Sherwood Landing Rd. | | | | 10f. Zip Code
21665 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home | | |
| 17. Father's Name (First, Middle, Last)
Albert Wrightson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
May Belle Ball | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary Jane Fairbank Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21907 Sherwood Landing Rd. Sherwood, Maryland 21665 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sherwood Cemetery Nov. 6, 1996 | | Data | | 20c. Location - City or Town, State
Sherwood Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Harrison E. Leonard</i> | | | | 22. Name and Address of Facility
Harrison E. Leonard Funeral Home
312 S. Talbot St. St. Michaels, Maryland 21663 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Arteriosclerotic Heart Disease with Acute Pulmonary Edema</i>
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
48 hrs |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>William Wood</i> | | 29c. License number
1705715 | | 29d. Date signed (Month, Day, Year)
11/3/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Wood M.D. 506 Idlewild Ave. Easton, Maryland 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV - 7 1996 | | 32. Registrar's Signature
<i>Galia Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34761

ITEM: 5 per F.H G-747 5-8-97 eoh

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Mildred Anderton Hofmann

2. Date of Death

November 5, 1996

3. Time of Death

5:45 P.M.

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

220-50-2703

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 16, 1921

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

McDaniel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9262 Pennywhistle Drive

10f. Zip Code

21647

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health

17. Father's Name (First, Middle, Last)

Harry C. Anderton

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Ida Makely

19a. Informant's Name/Relationship (Type, Print)

Ann Thompson

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1322 Woodridge Lane, Eldersburg, MD. 21784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Crematory

Date

11/6/96

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harrison E. Leonard Funeral Home

312 S. Talbot St., St. Michaels, MD. 21663

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Breast cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 1/2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

26a. Date of Injury (Month, Day, Year)

26b. Time of Injury

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DO 1225

29d. Date signed (Month, Day, Year)

11-6-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen P. Carney, M. D. 509 Idlewild Avenue, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

NOV - 7 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34762

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLIE HENRY HACKNEY

2. Date of Death

Month Day Year
OCTOBER 31 1996

3. Time of Death

6:55 AM
FOUND

4a. Facility Name (If not institution, give street and number)

4212 28th STREET

4b. City, Town, or Location of Death

MT. RAINIER, MARYLAND

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

246-48-6043

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 18, 1933

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Mount Rainier

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4212 - 28th Street, Apt. 2

10f. Zip Code

20712

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

Aug. 1954 - July 1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Audio Visual Production Assistant

16b. Kind of Business/Industry

D.C. Public Schools

17. Father's Name (First, Middle, Last)

Levie

F.

Hackney, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Cladie

Atwater

19a. Informant's Name/Relationship (Type, Print) (wife)

Francine Marie Stevens Hackney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4212 - 28th Street, Apt. 2; Mount Rainier, Maryland 20712

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

Nov. 4, 1996

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Latney's Funeral Home, Inc.
3831 Georgia Avenue, N.W.; Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CANCER OF THE LUNG

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DEPUTY MEDICAL EXAMINER
D 33954

29d. Date signed (Month, Day, Year)

OCTOBER 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLUE JR MD 3001 HOSPITAL DR. CHEVERLY, MD 20784

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34763

| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Rosie Marie Hamlin | | | | 2. Date of Death
Month November Day 5 Year 1996 | | 3. Time of Death
1:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Doctors Community Hospital | | | | 4b. City, Town, or Location of Death
Lanham | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
578-80-1491 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
37 Yrs. | | 8. Date of Birth (Month, Day, Year)
02 03 59 | |
| | 9. Birthplace (State or Foreign Country)
Washington DC | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
New Carrollton | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
7715 Riverdale Road #203 | | 10f. Zip Code
20784 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Legal Clerk | | 16b. Kind of Business/Industry
Government | | 17. Father's Name (First, Middle, Last)
Frederick Douglass Hamlin | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Earline Tasker | | 19a. Informant's Name/Relationship (Type, Print)
Katrina Mills/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7715 Riverdale Road #203, New Carrollton MD 20784 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Location - City or Town, State
Landover, Maryland | | 21. Signature of Funeral Service Licensee
Nancy A. Perentie | | 22. Name and Address of Facility
J. B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. End Stage AIDS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the causes of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pneumocystis pneumonia | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Anastasia Yordan MD | | 29c. License number
50454 | |
| State Registrar | 29d. Date signed (Month, Day, Year)
11/7/96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anastasia Yordan 8118 Good Luck Road Lanham MD 20706 | | 31. Date filed (Month, Day, Year)
NOV 08 1996 | | 32. Registrar's Signature
Johanna Anderson-Randall | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

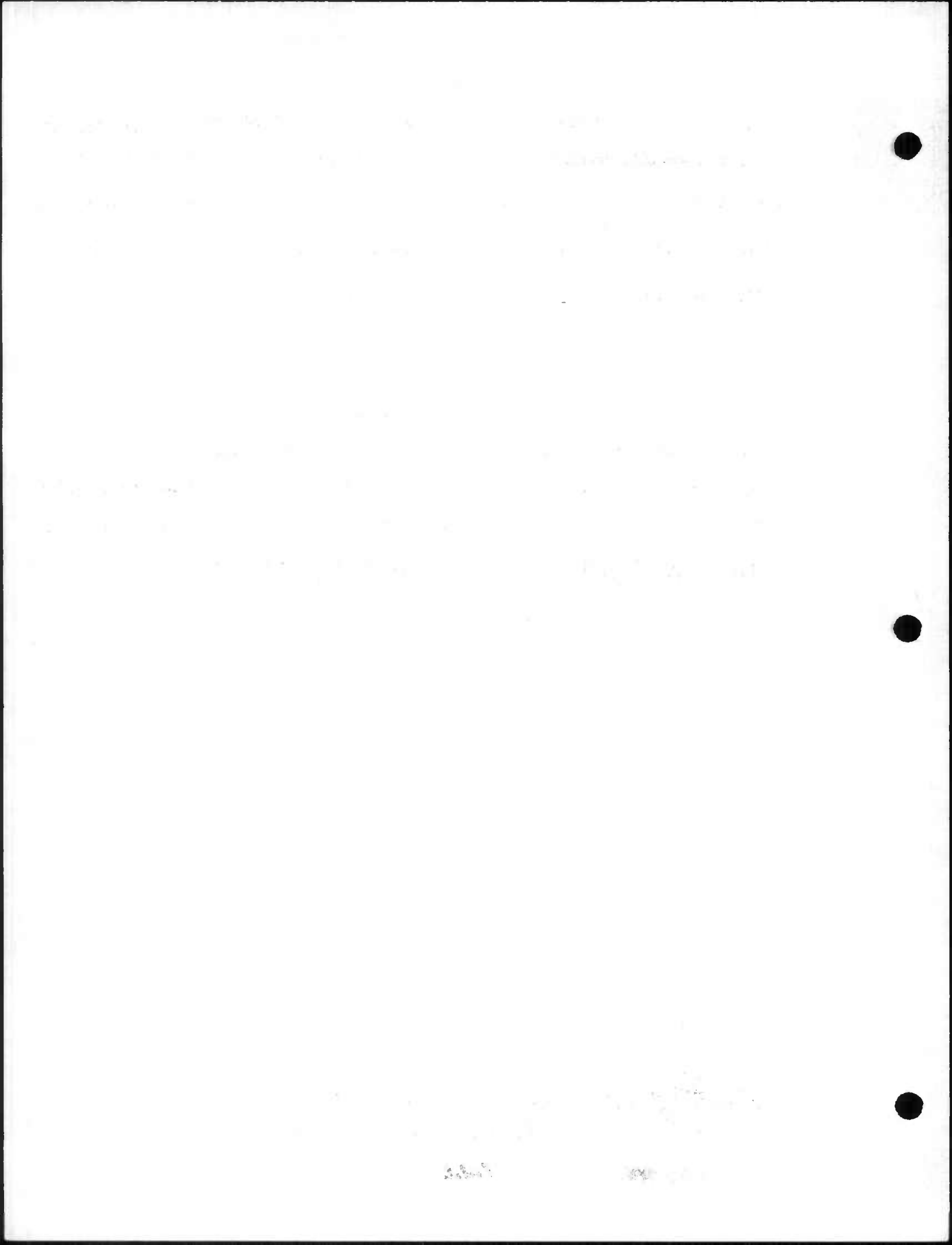
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34764

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Houchens Sr.

2. Date of Death

Month Day Year
NOV 1 1996

3. Time of Death

11:10 AM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel, MD

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

578-30-7904

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 6 1927

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State
MD

10b. County

Prince Georges

10c. City, Town or Location

Laurel, MD

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9225 C Bridle Path Lane

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 45-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Building

17. Father's Name (First, Middle, Last)

George Houchens

18. Mother's Name (First, Middle, Maiden Surname)

Willie Williams

19a. Informant's Name/Relationship (Type, Print)

John M. Houchens Jr. Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

978 Summer Hill Drive Gambrills Md. 21054

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 11/4/96

Data

20c. Location - City or Town, State

Crownsville Md.

21. Signature of Funeral Service Licensee

Robert E. Evans Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Carcinoma of the Lung
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lynne A. Gaynes MD

29c. License number

D25775

29d. Date signed (Month, Day, Year)

11/1/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lynne A. Gaynes MD, 14201 Laurel Park Dr, Laurel MD 20707

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

John D. ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34765
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANN ELIZABETH HARKINS

2. Date of Death

Month Day Year
October 24, 1996

3. Time of Death

10:44 AM

4a. Facility Name (If not institution, give street and number)

2905 Grier Nursery Road

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

213-28-8380

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 8, 1927

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2905 Grier Nursery Road

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Environmental Services Tech.

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Charles Michael Lynch

18. Mother's Name (First, Middle, Maiden Surname)

Claudia (u/k) Givins

19a. Informant's Name/Relationship (Type, Print)

John W. Harkins-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2905 Grier Nursery Rd., Forest Hill, Md. 21050

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Deer Creek U.M. Cemetery

Date

10/28/96

20c. Location - City or Town, State

Forest Hill, Md.

21. Signature of Funeral Service Licensee

Howard K. McComas III

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Md. 21009

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ovarian Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Douglas J. Harkins

29c. License number

043934

29d. Date signed (Month, Day, Year)

10/25/96

30. Name and address of person who completed cause of death (If am 23e) (Type, Print)

DAUGHT IM.M.P. 301 ST. PAUL PLACE BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

OCT 28 1996

John Harkins

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34766

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Douglas Kelvin Hamilton 2. Date of Death Month November Day 06 Year 1996 3. Time of Death 13:58

4a. Facility Name (If not Institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Death

Fallston General Hospital

Fallston

Harford

Funeral
Director

5. Social Security Number

6. Sex ☒ M ☐ F

7. Age (In yrs. last birthday) 84 Yrs.

If Under 1 Year Months Days

If Under 24 Hrs. Hours Min.

8. Date of Birth (Month, Day, Year) 8/26/1912

9. Birthplace (State or Foreign Country) Illinois

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Florida

Charlotte

Harbor Heights

☐ Yes ☒ No

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

2968 Peace River Drive

33983

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 4

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Banker

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Douglas Thomas

Hamilton

18. Mother's Name (First, Middle, Maiden Surname)

Alice

Clark

19a. Informant's Name/Relationship (Type, Print)

Sandra E. Owen/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3807 Justin Rd. Monkton, Maryland 21111

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

11/8

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

M. Blacken Kurfess

22. Name and Address of Facility

Kurtz Funeral Home, P.A.
Jarrettsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Myocardial Infarction

Due to (or as a consequence of):

10 minutes

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Initial Myocardial Infarction

Due to (or as a consequence of):

1 month

c. Chronic ischemic heart disease

Due to (or as a consequence of):

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostatic Cancer

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient

☒ Outpatient

☐ DOA

Other: ☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Dooley, MD

29c. License number

29d. Date signed (Month, Day, Year)

November 06, 1996

30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)

Robert Dooley MD 8530 Pleasant Plains, Baltimore, MD 21286

31. Date filed (Month, Day, Year)

NOV 8 1996

Registrar's Signature

John Anderson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

• • • •

4

4

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34767

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEE AUSTIN HYRE | | | | 2. Date of Death
Month November Day 5 Year 1996 | | 3. Time of Death
11:30 am | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| Funeral
Director | 5. Social Security Number
214-07-1733 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV 16, 1912 | |
| | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | 10a. State
PA | | 10b. County
BEDFORD | | 10c. City, Town or Location
HYNDMAN | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
R. D. 1, BOX 33 | | 10f. Zip Code
15545 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HEAVY EQUIPMENT OPERATOR | | 16b. Kind of Business/Industry
NATURAL GAS | | | |
| | 17. Father's Name (First, Middle, Last)
DANIEL E. HYRE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
CLARA Y. RIGGLEMAN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ELSIE T. HYRE/ SPOUSE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
R. D. 1, BOX 33, HYNDMAN, PA 15545 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PORTER CEMETERY NOV. 8, 1996 | | 20c. Location - City or Town, State
RD, HYNDMAN, PA 15545 | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
HARVEY H. ZEIGLER FUNERAL HOME
HYNDMAN, PA 15545-0636 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular accident
Due to (or as a consequence of):

b. Carotid stenosis
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 23c. Were an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 23d. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation
Aspiration pneumonia | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D 25406 | | 29d. Date signed (Month, Day, Year)
November 6, 1996 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. William Lamm, 47 Virginia Ave., Cumberland, MD 21502 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 07 1996 | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34768

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BESSIE HOUSE

2. Date of Death

November 4 1996

3. Time of Death

12:40 PM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

232-26-0425

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 2, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegheny

10c. City, Town or Location

Rawlings

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23713 McMullen Hwy S.W.

10f. Zip Code

21557

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William E. Iser

18. Mother's Name (First, Middle, Maiden Surname)

Julia Catherine Dawson

19a. Informant's Name/Relationship (Type, Print)

Alda K. Westfall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

General Delivery New Creek, WV 26743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dawson Cemetery Nov 7, 1996

Date

20c. Location - City or Town, State

Rawlings, MD 21557

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rotruck-Smith Funeral Home
85 South Main Street Keyser, WV 2672623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. *RESPIRATORY Failure*
Due to (or as a consequence of):b. *Cerebrovascular Accident*
Due to (or as a consequence of):c. *Cerebral Atherosclerosis*
Due to (or as a consequence of):d.
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

1 day

2 hrs

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure, IDDM, Diabetic Nephropathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 19318

29d. Date signed (Month, Day, Year)

Nov-7th 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. RANJITHAN M.D., 517 OLDTOWN ROAD, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature

96 34769

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
VOLORUS HALVER HOUGEN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOVEMBER 2 1996 | | 3. TIME OF DEATH
5:45 A M | |
| 4. SOCIAL SECURITY NUMBER
216-44-6621 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 27, 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Brooke Grove Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Olney | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Silver Spring | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3446 Gleneagles Drive | | | | 10f. ZIP CODE
20906 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Administrator | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. State Department | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Halver Hougen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mathilda F. | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Esther Brown Hougen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3446 Gleneagles Drive Silver Spring, Maryland 20906 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory 11/3/96 Alexandria, Virginia | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Steven D. Strind</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Francis J. Collins Funeral Home, Inc. 20901
500 University Blvd., W. Silver Spring, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
a. URETERAL OBSTRUCTION
DUE TO (OR AS A CONSEQUENCE OF):
c. METASTATIC PROSTATIC CARCINOMA
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
4 WEEKS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
EMPHYSEMA
CONGESTIVE HEART FAILURE
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>T.E. Howe, MD</i> | | | | 29c. LICENSE NUMBER
D33700 | | 29d. DATE SIGNED (Month, Day, Year)
NOVEMBER 2, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
TED E. HOWE 7542 OVERLOOK DRIVE, BOONSBORO, MD 21713 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 06 1996 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34770

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carl Curtis

2. Date of Death

November 4, 1996

3. Time of Death

0635

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

486-03-9791

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

September 10, 1910

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

172 Kendrick Place #14

10f. Zip Code

20878

10g. Citizen of What Country?

United States

of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Civil Service With Department of the Navy

17. Father's Name (First, Middle, Last)

William Luther Horner

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Frances Noe

19a. Informant's Name/Relationship (Type, Print)

Helen B. Horner (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

172 Kendrick Place #14, Gaithersburg, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cayucos Morro Bay Cemetery 15, 1996

Date

November

20c. Location - City or Town, State

Cayucos, California

21. Signature of Funeral Service Licensee #M00690

Howard A. Carson

22. Name and Address of Facility

DeVol Funeral Home of Gaithersburg

10 East Deer Park Drive, Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert L. Gold MD

29c. License number

29300

29d. Date signed (Month, Day, Year)

November 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Gold 15225 Shady Grove Road Rockville, Md

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the implementation of these practices. It details the steps involved in setting up a robust system for data collection and analysis. This includes identifying the key areas of focus, selecting appropriate tools and technologies, and training staff to ensure they are equipped to handle the data effectively. The goal is to create a seamless process that allows for easy access and interpretation of the information.

3. The third part of the document addresses the challenges that may arise during the implementation process. It acknowledges that there can be resistance to change and that some staff may struggle with the new system. To overcome these challenges, the document suggests several strategies, such as providing ongoing support and training, and encouraging a culture of continuous improvement. It also highlights the importance of regular communication and feedback to ensure that the system remains relevant and effective.

4. The final part of the document provides a summary of the key findings and conclusions. It reiterates the importance of accurate record-keeping and the need for a well-implemented system. The document also offers some final thoughts on the future of data management and the role of technology in this process. It concludes by expressing confidence in the organization's ability to successfully implement these practices and achieve its goals.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34771

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED ERIC HEONEY

2. Date of Death

Month Day Year
OCTOBER 31, 1996

3. Time of Death

4:00 PM

4a. Facility Name (If not institution, give street and number)

MARINER NURSING HOME

4b. City, Town, or Location of Death

KENSINGTON

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

174-28-4693

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 16, 1906

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10250 Westlake Drive

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1943/194513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Portrait Photographer

16b. Kind of Business/Industry

Photography

17. Father's Name (First, Middle, Last)

Joseph Heoney

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Eleonore Hohne

19a. Informant's Name/Relationship (Type, Print)

Rosalind A. Baur/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

509 Mannakee Street, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Mary's Cemetery

Date

11/4/96

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DEVOL FUNERAL HOME

10 EAST DEER PARK DR., GAITHERSBURG, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 year

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

NOVEMBER 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONALD SHUMACHER, M.D., 9707 MEDICAL CENTER DR., #310 ROCKVILLE, MD 20850

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 06 1996

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

96 34772

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROSE HINDEN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOVEMBER 3 1996 | | 3. TIME OF DEATH
12-56 PM | |
| 4. SOCIAL SECURITY NUMBER
069-36-2756 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
94 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
AUG. 15, 1902 | | 8. BIRTHPLACE (State or Foreign Country)
NEW YORK | |
| 9a. FACILITY NAME (If not institution, give street and number)
HEBREW HOME OF GREATER WASHINGTON | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ROCKVILLE | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
ROCKVILLE | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6121 MONTROSE ROAD | | | | 10f. ZIP CODE
20852 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
ABRAHAM KROSHINSKY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SARAH "UNKNOWN" | | | |
| 19a. INFORMANT'S NAME (Type/Print)
STANLEY HINDEN (SON) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3310 N. LEISURE WORLD BLVD. #630 - SILVER SPRING, MD | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
NEW MONTEFIORE CEMETERY | | DATE
11/6 | | 20c. LOCATION — City or Town, State
FARMINGDALE, NEW YORK | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Frank A. Stone</i> | | | | 22. NAME AND ADDRESS OF FACILITY
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
HYPERTENSION
DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
MONTHS

YEARS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>P. Talwar, M.D.</i> | | | | 29c. LICENSE NUMBER
D 36552 | | 29d. DATE SIGNED (Month, Day, Year)
NOVEMBER 4 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
P. TALWAR, 6121 MONTROSE RD. ROCKVILLE MD. 20852 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 07 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>Davidson-Rendell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34773

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--------------------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Paul Jens Henriksen | | | | 2. Date of Death
Month November Day 6 , Year 1996 | | 3. Time of Death
4:16pm | |
| | 4a. Facility Name (If not institution, give street and number)
3130 Beckenham Court | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
082-07-3032 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 28, 1908 | |
| | Usual Residence of Decedent | | 10a. State
Md. | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| To Be Completed by Funeral Director | 10e. Street and Number
3130 Beckenham Court | | | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Commercial Artist | | 16b. Kind of Business/Industry
Advertising | | | |
| | 17. Father's Name (First, Middle, Last)
Jens Henriksen | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Karen Jacobsen | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Diane H. Burke (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
#1 Leopold Court Derwood, Md. 20855 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
Nov. 7 1996 | | 20c. Location - City or Town, State
Alexandria, Va. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
DeVol Funeral Home
10 East Deer Park Drive Gaithersburg, Md. 20877 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Acute Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. c. d.
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | |
| | Approximate Interval Between Onset and Death
5 Minutes | | | | | | | |
| | Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D08546 | | 29d. Date signed (Month, Day, Year)
November 7, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. John Tauber 8218 Wisconsin Ave. Bethesda, Md. 20814 | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
NOV 08 1996 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1040 1/2 1/2 1/2

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1040 1/2 1/2 1/2

1040

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34774

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene Francis Hawley

2. Date of Death

Month Day Year
October 30 1996

3. Time of Death

2350

4e. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

183-14-5624

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 27, 1920 Pennsylvania

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10e. State
Maryland
10b. County
Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8817 Cold Spring Road

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

World

War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Joseph A. Hawley

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Luft

19a. Informant's Name/Relationship (Type, Print)

Mary J. Hawley/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8817 Cold Spring Road, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

November 2, 1996

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

David E. Perry

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Inc. 300 West Montgomery Avenue,

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e.

Anoxic Encephalopathy

Due to (or as a consequence of)

9 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Ventricular Tachycardia + Fibrillation

Due to (or as a consequence of)

9 hours

c.

Cardiomyopathy

Due to (or as a consequence of)

1988

d.

Mitral Regurgitation - Severe

Due to (or as a consequence of)

1988

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mitral Valve prolapse, prostate cancer,

Right Bundle Branch Block

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John J. Preece MD

29c. License number

35261

29d. Date signed (Month, Day, Year)

October 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John J. Preece MD 3801 International Dr #210 Silver Spring MD 20906

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

IGNAZ HORVATH
82450169

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34775

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

IGNAZ

HORVATH

2. Date of Death
Month Day Year

Nov 5 1996

3. Time of Death

1:38

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

none

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 11, 1944

9. Birthplace (State or Foreign Country)

Hungary

Usual Residence of Decedent

10e. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

Maryland Montgomery

Silver Spring

10e. Street and Number

2016 Kings House Road

10f. Zip Code

20905

10g. Citizen of What Country?

Germany

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Auto Mechanic

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Ignaz Horvath

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bauer

19e. Informant's Name/Relationship (Type, Print)

Reiner Horvath

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2016 Kings House Road Silver Spring, Maryland 20905

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

11/06/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Robert Ramsey

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

5 ☐ Pending Investigation

2 ☐ Accident

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Gaudin MD

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Nov 5 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John W. Gaudin

8218 Wisconsin Ave Bethesda

State
Registrar

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34776

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Mary B. Hendry</u> | | | | 2. Date of Death
Month <u>November</u> Day <u>2</u> Year <u>1996</u> | | 3. Time of Death
<u>5:58 PM</u> | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Montgomery General Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Olney</u> | | 4c. County of Death
<u>Montgomery</u> | | |
| Funeral
Director | 5. Social Security Number
<u>058-16-1287</u> | | 8. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>89</u> Yrs. | | If Under 1 Year
Months Days | | |
| | 6. Date of Birth (Month, Day, Year)
<u>June 25, 1907</u> | | 9. Birthplace (State or Foreign Country)
<u>Massachusetts</u> | | 10. Usual Residence of Decedent
10a. State <u>Maryland</u> 10b. County <u>Montgomery</u> 10c. City, Town or Location <u>Silver Spring</u> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <u>3701 International Drive, Apt 219</u> 10f. Zip Code <u>20906</u> 10g. Citizen of What Country? <u>USA</u> | | |
| To Be Completed by Funeral Director | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | |
| | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u> <u>1</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Homemaker</u> | | 16b. Kind of Business/Industry
<u>Own Home</u> | | | |
| To Be Completed by Physician/Medical Examiner | | 17. Father's Name (First, Middle, Last)
<u>Michael Leary</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Ellen Burke</u> | | | |
| | | 19a. Informant's Name/Relationship (Type, Print)
<u>Richard M. Burns</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>3237 Beaverwood Lane Silver Spring, Maryland 20906</u> | | | |
| Physician
/Medical
Examiner | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Gate of Heaven Cemetery</u> | | 20c. Location - City or Town, State
<u>11/09/96 Silver Spring, Maryland</u> | | | |
| | | 21. Signature of Funeral Service Licensee
<u>James S. Dooly</u> | | 22. Name and Address of Facility
<u>Francis J. Collins Funeral Home, Inc.</u>
<u>500 University Blvd., W. Silver Spring, MD 20901</u> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>a. Cerebrovascular Accident</u>
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
<u>Three Days</u> | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 5 | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<u>[Signature]</u> | | 29c. License number
<u>033686</u> | | 29d. Date signed (Month, Day, Year)
<u>November 3, 1996</u> | |
| | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>Kenneth Miller, MD 1811 Prince Philip Dr. Olney, MD 20832</u> | | 31. Date filed (Month, Day, Year)
<u>NOV 06 1996</u> | | 32. Registrar's Signature
<u>Julia Davidson-Randall</u> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34777

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT LEE JACKSON

2. Date of Death

November 2, 1996

3. Time of Death

08:00 AM FOUND

4a. Facility Name (If not institution, give street and number)

9102 LOUGHRAN ROAD

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

223-14-6869

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6-2-14

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9102 Loughran Road

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sawmill laborer

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Jesse James Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Lydia Carter

19a. Informant's Name/Relationship (Type, Print)

Dorothy M. Jackson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9102 Loughran Rd., Ft. Wash., MD 20744

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Pentecostal Evan.Ch. 11-09 Spotsylvania Co. VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Strickland Funeral Service

6500 Allentown Rd. Camp Springs, MD 20748

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accidental ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

REPUTY MEDICAL EXAMINER
D 33954

29d. Date signed (Month, Day, Year)

NOVEMBER 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLLE JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34778

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Neale Jarboe, Jr.

2. Date of Death

Month Day Year
October 29, 1996

3. Time of Death

1:15 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Medical Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

579-09-1095

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 6, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3810 Nicholson Street

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Naval Ordinance Lab

17. Father's Name (First, Middle, Last)

Richard Neale Jarboe, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Elizabeth Beall

19a. Informant's Name/Relationship (Type, Print)

Tina M. Kleppinger (Granddaughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3204 Kimberly Road, Hyattsville, Maryland 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery 10/31/96 Silver Spring, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

W. Constance Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *SEPSIS*
Due to (or as a consequence of):b. *PANCREATITIS*
Due to (or as a consequence of):c. *Renal Failure*
Due to (or as a consequence of):d. *Pulmonary Failure*
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*CARCINOMA OF RECTUM**ABDOMINAL AORTIC ANEURYSM*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)4 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. Constance Gasch

29c. License number

D 2358L

29d. Date signed (Month, Day, Year)

11/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian S. Bayly MD 7223 HANDOVER PKWY GREENBELT MD 20770

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

*John Anderson*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4 20


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

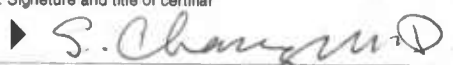

Certificate of Death

Reg. No.

96 34780

| | | | | | |
|---|--|--|---|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Clive W. James | | 2. Date of Death
Month November Day 10 Year 1996 | | 3. Time of Death
07:10 AM |
| | 4a. Facility Name (If not Institution, give street and number)
Frostburg Village Nursing Care Center | | 4b. City, Town, or Location of Death
Frostburg | | 4c. County of Death
Allegany |
| Funeral
Director | 5. Social Security Number
214-01-3760 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
22-Dec-02 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Florida | 10b. County
Sarasota | 10c. City, Town or Location
Englewood | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1231 Wilson Drive | | 10f. Zip Code
34223- | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Maintenance Dept. | | 16b. Kind of Business/Industry
Textiles |
| | 17. Father's Name (First, Middle, Last)
Albert James | | 18. Mother's Name (First, Middle, Maiden Surname)
Adella Smith | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Adelia McKenzie Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
200 Ormand Street Frostburg Maryland 21532- | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Frostburg Memorial Park | | 20c. Location - City or Town, State
13-Nov-96 Frostburg, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death |
| | a. Intractable CONGESTIVE Heart Failure | | | | 24 Hours |
| | b. Cardiomyopathy | | | | 3 years |
| | c. CORONARY artery Disease | | | | 10 years |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE Lung Disease
Lung mass, possibly neoplastic | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D25638 | | 29d. Date signed (Month, Day, Year)
November 11, 1996 |
| | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
S.T. Chang, MD., Frostburg Plaza, Frostburg, Maryland, 21532 | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 12 1996 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

2. The second part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

3. The third part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

4. The fourth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

5. The fifth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

6. The sixth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

7. The seventh part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 34781**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES T. JONES

2. Date of Death

Nov. 3, 1996

3. Time of Death

11:44 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

217-08-7221

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

26

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 7, 1969

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4212 Round Hill Rd,

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Timothy L. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Linda C. Smallwood

19a. Informant's Name/Relationship (Type, Print)

Heather M. Jones (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4212 Round Hill Rd, Wheaton. Md 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rockville Cemetery

Date

11/7

20c. Location - City or Town, State

Rockville, Md

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Snowden Funeral Home P.A. 20850
Rockville, Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Hanging
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

Found 11/3/96

28b. Time of Injury

10:55 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject hanged cell in cell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

JAIL CELL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Center Seven Locks Road Rockville

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

NOV. 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

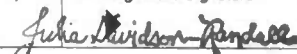
THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34782

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Henry Jackson

2. Date of Death

November 2, 1996

3. Time of Death

0840 A

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

218-16-2171

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

8. Date of Birth

June 27, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14030 Berryville Road

10f. Zip Code

20874

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Guard

16b. Kind of Business/Industry

Naval Medical Ctr.

17. Father's Name (First, Middle, Last)

Henry R. Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Brewer

19e. Informant's Name/Relationship (Type, Print)

Patricia Johnson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12652 Grey Eagle Ct., Germantown, MD 20874

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Seneca Church Cem.

Date

11/8/96

20c. Location - City or Town, State

Germantown, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Anterior Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic Stenosis

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D21334

29d. Date signed (Month, Day, Year)

November 2, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Daniel J. Goldberg 10401 Old Georgetown Rd - Bethesda, MD 20814

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

*[Signature]*State
Registrar

Baltimore, Maryland 21215-0020

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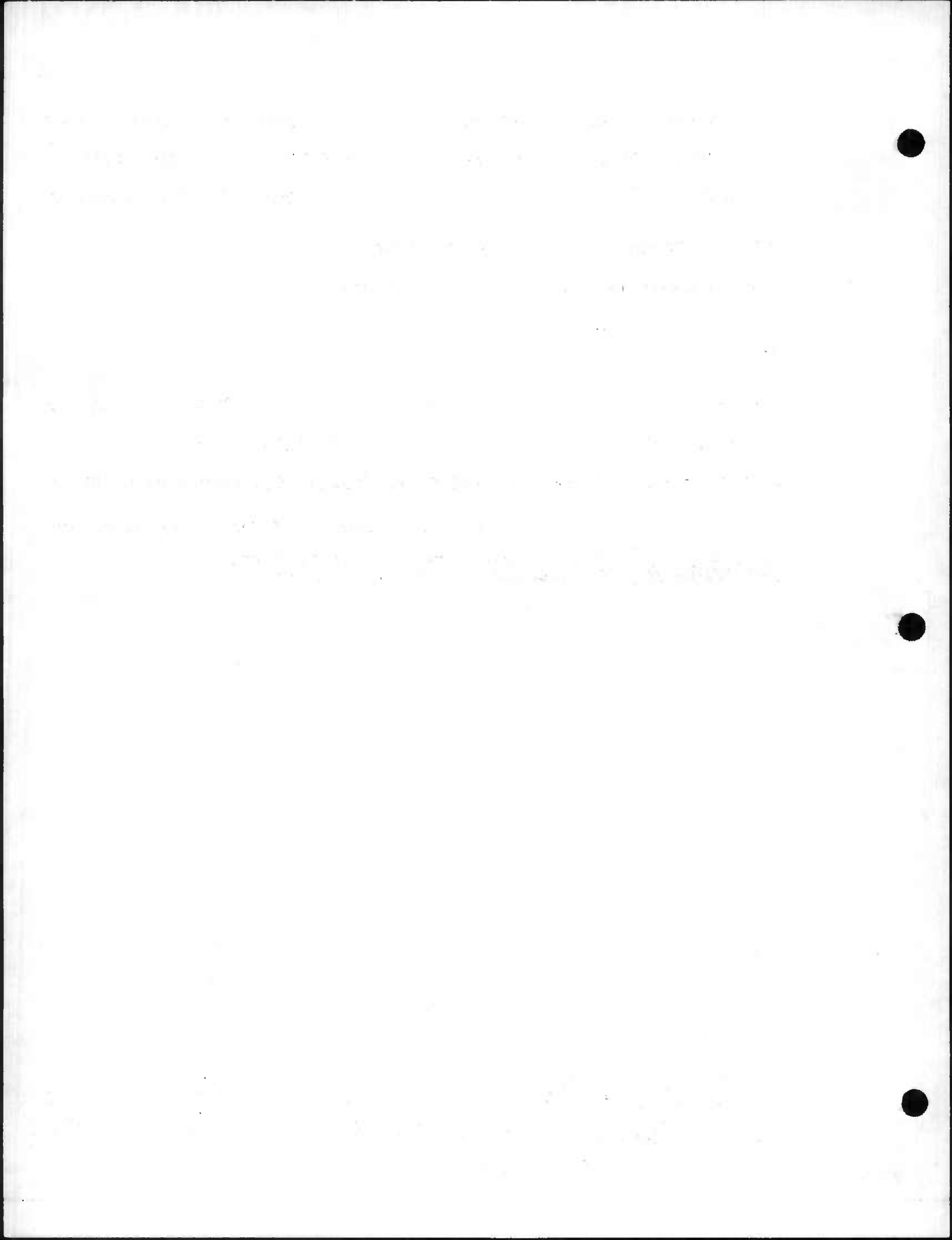
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34783

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
Elizabeth R. Jager | | | | 2. Date of Death
Month Day Year
November 4, 1996 | | 3. Time of Death
1:30 PM | |
| 4a. Facility Name (If not institution, give street and number)
4242 East-West Highway, Apt. 1115 | | | | 4b. City, Town, or Location of Death
Chevy Chase | | 4c. County of Death
Montgomery | |
| 5. Social Security Number
578-34-6710 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 1, 1925 | |
| 9. Birthplace (State or Foreign Country)
Washington D.C. | | 10. Usual Residence of Decedent
10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Chevy Chase 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Trade Relations | |
| 17. Father's Name (First, Middle, Last)
John A. Rodgers | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen Katzenstein | | 19. Informant's Name/Relationship (Type, Print)
Joan R. Shields | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6070 California Circle, Apt. 205, Rockville, MD 20852 | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rock Creek Cemetery | | 20c. Location - City or Town, State
11/8/96 Washington D.C. | | 21. Signature of Funeral Service Licensee
Eric S. Karbo | |
| 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd. W. Silver Spring, MD 20901 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Metastatic Carcinoma Lung | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23c. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 23d. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Charles P. Juvane | | 29c. License number
201221 | | 29d. Date signed (Month, Day, Year)
11/5/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles P. Juvane MD 3301 NEW MEXICO AVE NW WASH DC | | 31. Date filed (Month, Day, Year) | | 32. Registrar's Signature | | 33. State Registrar | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34784

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Johnson C Johnson, Jr.

2. Date of Death

Nov 5 1996

3. Time of Death

2:20 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

046-05-4691

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 1, 1904

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

512 Carr Avenue

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Insurance Company

17. Father's Name (First, Middle, Last)

Andrew C. Johnson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bridget Flynn

19a. Informant's Name/Relationship (Type, Print)

Miriam E. Sacks

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

512 Carr Avenue Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Mary's Cemetery

Date

11/09/96

20c. Location - City or Town, State

East Hartford,
Connecticut

21. Signature of Funeral Service Licensee

Eric S. Sacks

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Silver Spring, MD 20901

23a. Pertinent, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Coronary Artery Disease

Due to (or as a consequence of):

b.

Sepsis

Due to (or as a consequence of):

c.

Dementia and Chronic Renal Failure

Due to (or as a consequence of):

d.

Pneumonia

Approximate
Interval Between
Onset and Death

1 day

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombophlebitis right leg - superficial
cellulitis right leg

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accidental 6 ☐ Could not be
determined
3 ☐ Suicidal 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric S. Sacks

29c. License number

041290

29d. Date signed (Month, Day, Year)

Nov 5 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8300 Conformation Drive, Landover MD 20785

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ITEMS: 23 PART I, 27, PER ME0
FILM G-741 11/26/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34785

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedant's Name (First, Middle, Last)
BENJAMIN FRANKLIN JACOBS | | | | 2. Date of Death
Month Day Year
OCTOBER 28 1996 | | 3. Time of Death
10:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
7808 KLOVSTAD DRIVE | | | | 4b. City, Town, or Location of Death
FT. WASHINGTON | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
149-32-7271 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
52 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 6, 1943 | |
| | 9. Birthplace (State or Foreign Country)
New Jersey | | 10a. State
Maryland | | 10b. County
Prince Georges | | 10c. City, Town or Location
Ft. Washington | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
7808 Klovstad Drive | | 10f. Zip Code
20744 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedant's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4 or 5+) 4 | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Computer Analyst | | 16b. Kind of Business/Industry
Washington National Cemetery | | 17. Father's Name (First, Middle, Last)
Benjamin F. Jacobs, Jr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Anne Merrill | | 19a. Informant's Name/Relationship (Type, Print)
Desrine L. Jacobs Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7808 Klovstad Drive, Ft. Washington, MD 20744 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakeview Memorial | | 20c. Location - City or Town, State
Cinnamons, NJ | | 21. Signature of Funeral Service Licensee
<i>Harvey E. Heath</i> | | 22. Name and Address of Facility
McGuire Funeral Service, Inc. 20012
7400 Georgia Avenue, N.W., Washington, D.C. | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Stephen S. Radentz MD</i> | |
| State Registrar | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
OCTOBER 29, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
NOV 07 1996 | |
| | 32. Registrar's Signature
<i>Davidson-Randall</i> | | | | | | | |

EXHIBIT 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34786

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Anthony Jacques | | | | 2. Date of Death
Month Day Year
November 4, 1996 | | 3. Time of Death
10:50 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
629 Aster Blvd. | | | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
019-30-7301 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
58 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 15, 1938 | |
| | 9. Birthplace (State or Foreign Country)
Washington, DC | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
629 Aster Blvd. | | 10f. Zip Code
20850 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Attorney | | 16b. Kind of Business/Industry
Law | | 17. Father's Name (First, Middle, Last)
Howard Francis Jacques | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Mary Shea | | 19a. Informant's Name/Relationship (Type, Print)
Mary S. Jacques, Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9600 Dewmar Lane, Kensington, MD 20895 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | 20c. Location - City or Town, State
Silver Spring, Maryland | | 21. Signature of Funeral Service Licensee
<i>Michael D. Cihlar</i> | | 22. Name and Address of Facility
DeVol Funeral Home
10 E. Deer Park Dr., Gaithersburg, MD. 20877 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Cardiac arrest & arrhythmia
a. Due to (or as a consequence of):
Acute myocardial infarction
b. Due to (or as a consequence of):
Cardiomyopathy ischemic
c. Due to (or as a consequence of):
Diabetes mellitus I
d. | | Approximate Interval Between Onset and Death
acute
acute
years
Years | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>John S. Saia M.D.</i> | | |
| 29c. License number
10493 D | | 29d. Date signed (Month, Day, Year)
November 5, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John S. Saia, M.D., 809 Veirs Mill Road, Rockville, Maryland 20851 | | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | |
| 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form and released by the Medical Examiner.

*Cleared & Released by Medical Examiner 11/4/96

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1510

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34787

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>M. LORDED M Keplinger</i> | | | | 2. Date of Death
Month <i>11</i> Day <i>3</i> Year <i>96</i> | | 3. Time of Death
<i>14:40</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Dorchester General Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Cambridge MD</i> | | 4c. County of Death
<i>Dorchester</i> | |
| Funeral
Director | 5. Social Security Number
<i>214-12-9689</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>86</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>SEPT. 15, 1910</i> | 9. Birthplace (State or Foreign Country)
<i>MARYLAND</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>MARYLAND</i> | | 10b. County
<i>DORCHESTER</i> | | 10c. City, Town or Location
<i>CAMBRIDGE</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10a. Street and Number
<i>520 GLENBURN AVENUE</i> | | | | 10f. Zip Code
<i>21613</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>WHITE</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> <i>7</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>HOMEMAKER</i> | | 18b. Kind of Business/Industry
<i>OWN HOME</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>JOSEPH A. WILLEY</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>EMMA McGRATH</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>WINIFRED K. WHITE</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>106 BUENA VISTA AVENUE, CAMBRIDGE, MD 21613</i> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>DORCHESTER MEMORIAL PARK</i> | | Date
<i>11/6</i> | | 20c. Location - City or Town, State
<i>CAMBRIDGE, MARYLAND</i> |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>ZELLER FUNERAL HOME 106 MAIN STREET
P.O. BOX 207, EAST NEW MARKET, MD 21631</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
<i>Sepsis</i> | | | | | | | | <i>240</i> |
| Due to (or as a consequence of):
<i>Hemorrhagic Cystitis</i> | | | | | | | | <i>1 week</i> |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Gastrointestinal Bleeding,
Congestive Heart Failure, Renal
Insufficiency</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> <i>How Nan D.O.</i> | | 29c. License number
<i>H 44615</i> | | 29d. Date signed (Month, Day, Year)
<i>11/3/96</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>LOIS NARR, D.O., 215 BLOOMINGDALE AVENUE, FEDERALSBURG, MD 21632</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>NOV - 8 1996</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34788

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mae Gilmore Kent

2. Date of Death

Month Day Year
November 13, 1996

3. Time of Death

7:59pm

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

240-01-1269

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
04/04/1901

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Charles

10c. City, Town or Location

Welcome

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8275 Melody Acres Drive

10f. Zip Code

20693

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Edward E. Gilmore

18. Mother's Name (First, Middle, Maiden Surname)

Birdie Long Gilmore

19a. Informant's Name/Relationship (Type, Print)

Deborah Koepper Grandchild

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8275 Melody Acres Dr. Welcome, Md. 20693

20a. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Park Cemetery

Date

11/16/96

20c. Location - City or Town, State

Wolfstown, Va.

21. Signature of Funeral Service Licensee

Joseph W. Preddy

22. Name and Address of Facility

250 West Main St.
Preddy Funeral Home Orange, Va. 22960

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Peripheral Vascular Disease

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B Z

29c. License number

D-33426

29d. Date signed (Month, Day, Year)

11/14/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jenkins, Jr., B. Larry, MD 111 La Grange Ave., P.O. Box 1724, La Plata, MD 20646

31. Date filed (Month, Day, Year)

NOV 19 1996

32. Registrar

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34789

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BARBARA JEAN DISHMAN KELLY

2. Date of Death

Month Day Year
NOVEMBER 3, 1996

3. Time of Death

12:58 AM

4a. Facility Name (If not institution, give street and number)

2318 LAKEWOOD ST.

4b. City, Town, or Location of Death

SUITLAND

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

579-48-4477

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN. 4, 1934

9. Birthplace (State or Foreign Country)

JACKSON, MS

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

SUITLAND

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2318 LAKEWOOD ST.

10f. Zip Code

20746

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever In U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CASE ADMINISTRATOR

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

CLARENCE DISHMAN

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA JEFFERSON

19a. Informant's Name/Relationship (Type, Print)

DAUGHTERS

JACQUELINE WOOD/KAREN KELLY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2318 LAKEWOOD ST. SUITLAND, MD 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CEDAR HILL CEMETERY

Date

96

20c. Location - City or Town, State

SUITLAND, MD

21. Signature of Funeral Service Licensee

Alef S. Pope Jr.

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 MARLBORO PIKE FORESTVILLE, MD 20747

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ACUTE MYELOGENOUS LEUKEMIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Craig Kessler MD

29c. License number

DC 12669

29d. Date signed (Month, Day, Year)

11/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CRAIG KESSLER 2150 PENNSYLVANIA AVE. N.W. RM. 3-434 WASHINGTON, D.C. 20037

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the paper is devoted to a general discussion of the problem of the existence of solutions of the system of equations (1) and (2) under the conditions (3) and (4). It is shown that the system has a solution if and only if the conditions (5) and (6) are satisfied.

2. In the second part of the paper, the problem of the uniqueness of the solution of the system (1) and (2) is considered. It is shown that the system has a unique solution if the conditions (7) and (8) are satisfied.

3. In the third part of the paper, the problem of the stability of the solution of the system (1) and (2) is considered. It is shown that the solution is stable if the conditions (9) and (10) are satisfied. The stability of the solution is also investigated for the case of a perturbation of the initial conditions.

4. In the fourth part of the paper, the problem of the asymptotic behavior of the solution of the system (1) and (2) is considered. It is shown that the solution tends to zero as $t \rightarrow \infty$ if the conditions (11) and (12) are satisfied.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34790
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|--------------------------------------|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EMMA M. KIMBLE | | | | 2. Date of Death
Month 10 Day 26 Year 1996 | | | | 3. Time of Death
10 :30AM | |
| | 4a. Facility Name (If not institution, give street and number)
2017 GAITHER STREET | | | | 4b. City, Town, or Location of Death
TEMPLE HILLS | | | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
428-46-2805 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth
(Month, Day, Year)
3 17 1925 | | 9. Birthplace (State or Foreign Country)
MISSISSIPPI | | 10e. State
MD | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
TEMPLE HILLS | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
USA | | 10h. Street and Number
2017 GAITHER STREET | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) College (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SITE MANAGER | | 16b. Kind of Business/Industry
ST. TIMOTHY CATHOLIC | | 17. Father's Name (First, Middle, Last)
WILLIE NEAL | | 18. Mother's Name (First, Middle, Maiden Surname)
HELEN JOHNSON | | 19a. Informant's Name/Relationship (Type, Print)
EUGENE KIMBLE JR. HUSBAND | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2017 GAITHER STREET, TEMPLE HILLS, MD. 20748 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK | | Date
10/31/1996 | | 20c. Location - City or Town, State
GLANDOVER, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH ST. N.W. WASH, DC. 20011 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

HYPERTENSION
Due to (or as a consequence of):
DIABETES MELLITUS | | Approximate Interval Between Onset and Death | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
9584 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 6, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BARRY SMITH, M.D. 1328 SOUTHERN AVENUE, S.E. SUITE 213, WASHINGTON, DC. 20032 | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34791

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|---------------------------------------|--|--|---|---|----|--------------------------------|---|----|---------------------------------------|---------------|----|--|---------------|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WAYNE BERNELL KIDWELL | | | | 2. Date of Death
Month Day Year
November 4, 1996 | | 3. Time of Death
12:25 am | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital & Medical Center | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
723-14-5068 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 18, 1927 | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
PA | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| | 10a. State
WV | | 10b. County
Hampshire | | 10c. City, Town or Location
Romney | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| | 10e. Street and Number
HC 64, Box 1260 | | | | 10f. Zip Code
26757 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1946-'52 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Military | | 16b. Kind of Business/Industry
U.S. Army | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Alonza Martin Kidwell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Ethel Stockdill | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Jane E. Kidwell Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HC 64, Box 1260, Romney, WV 26757 | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Levels Cemetery | | Date
Nov. 6, 1996 | | 20c. Location - City or Town, State
Levels, WV | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Director
 | | | | 22. Name and Address of Facility
Shaffer Funeral Home, Inc.
230 East Main Street, Romney, WV 26757 | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Ischemic Encephalopathy</td> <td>Approximate Interval Between Onset and Death
2 Days</td> </tr> <tr> <td>b.</td> <td>Cardiac and Respiratory Arrest</td> <td>2 Days</td> </tr> <tr> <td>c.</td> <td>Probable Intestinal Obstruction</td> <td>5 Days</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Ischemic Encephalopathy | Approximate Interval Between Onset and Death
2 Days | b. | Cardiac and Respiratory Arrest | 2 Days | c. | Probable Intestinal Obstruction | 5 Days | d. | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Ischemic Encephalopathy | Approximate Interval Between Onset and Death
2 Days | | | | | | | | | | | | | | | | | |
| | b. | Cardiac and Respiratory Arrest | 2 Days | | | | | | | | | | | | | | | | | |
| | c. | Probable Intestinal Obstruction | 5 Days | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus, Previous CVA

Cigarette Abuse | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicida <input type="checkbox"/> Homicida | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Describe how injury occurred | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D 14393 | | 29d. Date signed (Month, Day, Year)
4/8/96 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Fred Miltenberger-Johnson Heights Medical Building-Cumberland, MD 21502 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 08 1996 | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #10d, 11/4/96, MRT, Montg. Cty. Certificate of Death

96 34792

Reg. No.

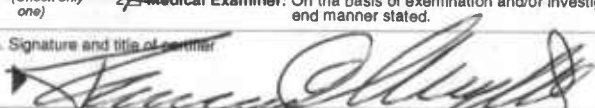
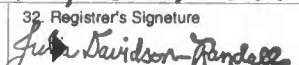
| | | | | | | | | | |
|---|--|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN JOSEPH KRAUSS | | | | 2. Date of Death
Month OCT Day 30 Year 96 | | 3. Time of Death
0819AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
111-12-7327 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 15, 1904 | | |
| | 9. Birthplace (State or Foreign Country)
New Jersey | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | | | 10b. County
Montgomery | | | | 10c. City, Town or Location
Rockville | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 10e. Street and Number
199 Rollins Avenue | | | | 10f. Zip Code
20852 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | | 16b. Kind of Business/Industry
Paper Mill | | |
| 17. Father's Name (First, Middle, Last)
George H. Krauss | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Julia Crosby | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Maureen T. Rich / Great Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1724 Boggs Road, Forest Hill, Maryland 21050 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery | | | 20c. Location - City or Town, State
Cheltenham, Maryland | | |
| 21. Signature of Funeral Service Licensee
 M00348 | | | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
ACUTE | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
707099 | | 29d. Date signed (Month, Day, Year)
OCT 30 96 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

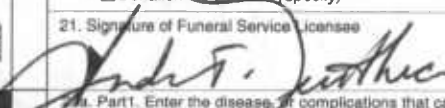


permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 34793**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|---------------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CECILIAMMA KALAPALA | | | | 2. Date of Death
Month October Day 31 , Year 1996 | | 3. Time of Death
5:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1408 Hampshire West, Apt. #6 | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
151-78-6714 | | 6. Sex
1 M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 17, 1921 | |
| | 9. Birthplace (State or Foreign Country)
India | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 Yes 2 No | | 10e. Street and Number
1408 Hampshire West, Apt. #6 | | 10f. Zip Code
20903 | | 10g. Citizen of What Country?
India | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Indian | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | 16b. Kind of Business/Industry
Education | | | |
| | 17. Father's Name (First, Middle, Last)
Veerayya Duri | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Mammaua | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Paul V. Kalapala - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1408 Hampshire West, Apt. #6, Silver Spring, MD 20903 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Washington Cem. 11-1-96 Adelphi, Maryland | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Ave., Silver Spring, MD 20904 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
RENAL FAILURE
Due to (or as a consequence of):
DIABETES MELLITUS
Due to (or as a consequence of):
STROKE
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
1 Wk. | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
STROKE | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of certifier

MD. | | 29c. License number
D 28656 | | 29d. Date signed (Month, Day, Year)
10/31/1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ravi Passi MD 8609 SECOND AVENUE #404 B, SILVER SPRING MD 20910 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

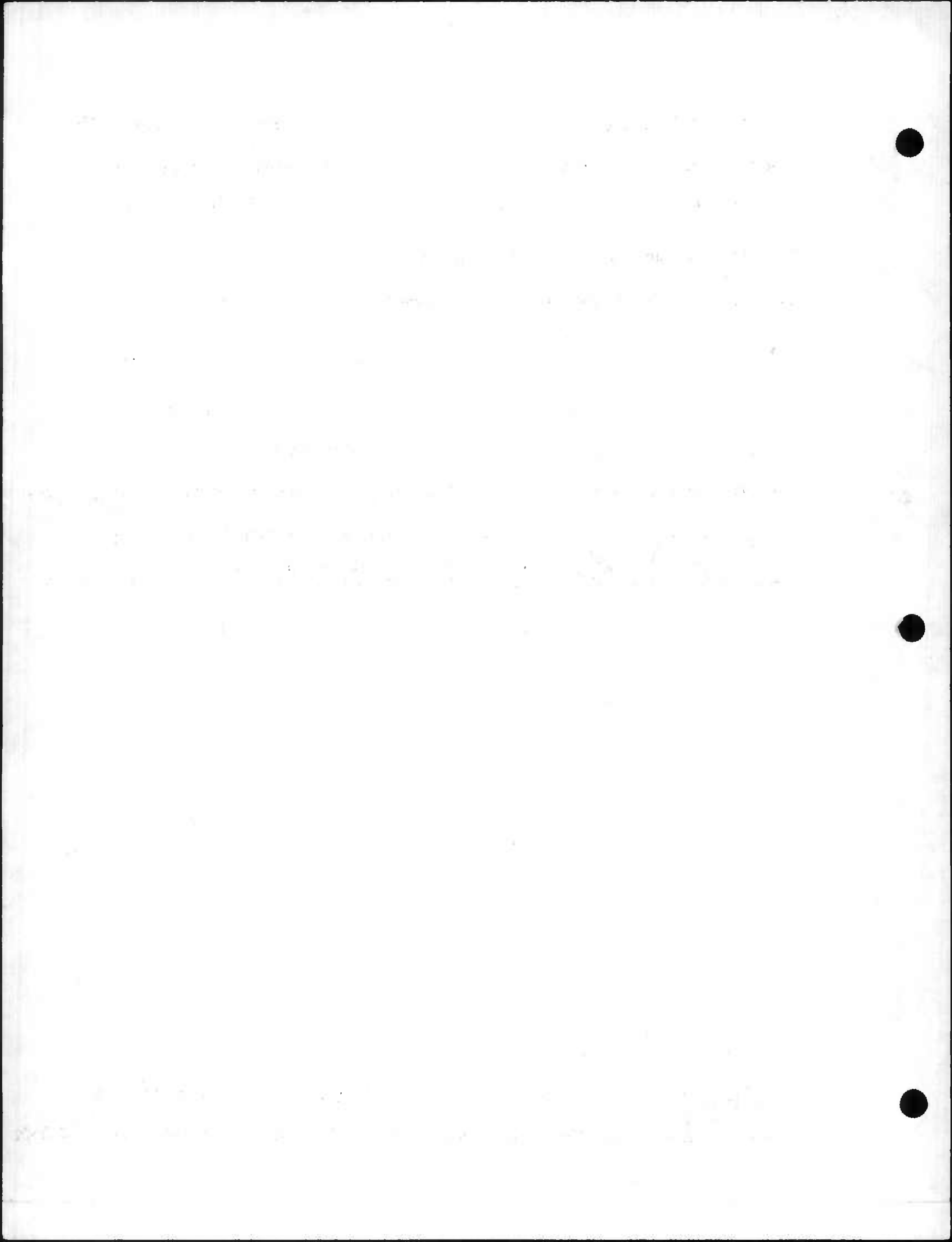
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34794

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LOIS SCHEIB KUFFNER | | | | | | 2. Date of Death
Month Day Year
OCT 30 1996 | | 3. Time of Death
0301 AM | |
| | 4a. Facility Name (If not institution, give street and number)
NATIONAL NAVAL MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death
BETHESDA, MD | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
215-68-8911 | | 8. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 6. Date of Birth (Month, Day, Year)
Feb. 16, 1918 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10. Usual Residence of Decedent
10a. State: Maryland 10b. County: Montgomery 10c. City, Town or Location: Rockville 10d. Inside City Limits: 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 11. Street and Number
110 Evans Street | | 12. Zip Code
20850 | |
| To Be Completed by Funeral Director | 13. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 14. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 15. Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 16. Race - American Indian, Black, White, etc.
Specify: White | | 17. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
4 | |
| | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | 19. Kind of Business/Industry
Public School | | 20. Father's Name (First, Middle, Last)
Walter Scheib | | 21. Mother's Name (First, Middle, Maiden Surname)
Edna Kredel | | 22. Intendant's Name/Relationship (Type, Print)
John E. Kuffner / Husband | |
| To Be Completed by Physician/Medical Examiner | 23. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 24. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. | | 25. Date
November 1, 1996 | | 26. Location - City or Town, State
Bethesda, Maryland | | 27. Signature of Funeral Service Licensee
<i>Michael J. Kutto</i> | |
| | 28. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 W. Montgomery Avenue,
Rockville, Maryland 20850-2805 | | 29. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
4 DAYS | | 30. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 31. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 32. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 33. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 34. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 35. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 36. Date of Injury (Month, Day, Year) | | 37. Time of Injury
M | |
| | 38. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 39. Describe how injury occurred | | 40. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 41. Location (Street and Number or Rural Route Number, City or Town, State) | | 42. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| State Registrar | 43. Signature and title of certifier:
R. P. SHARPE, LT MC, USN | | 44. License number
D-43873 | | 45. Date signed (Month, Day, Year)
OCT 31, 1996 | | 46. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD | | 47. Date filed (Month, Day, Year)
NOV 04 1996 | |
| | 48. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | | | | |

96 34795

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Mildred Kosowski</u> | | | | 2. DATE OF DEATH
MONTH <u>11</u> DAY <u>4</u> YEAR <u>96</u> | | 3. TIME OF DEATH
<u>2:30 AM</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>173-07-2942</u> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>84</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>March 30, 1912</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>Pennsylvania</u> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<u>Pleasant View Nursing Home</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Mt. Airy</u> | |
| 9c. COUNTY OF DEATH
<u>Carroll</u> | | | | 10a. STATE
<u>Maryland</u> | | 10b. COUNTY
<u>Montgomery</u> | |
| 10c. CITY, TOWN OR LOCATION
<u>Damascus</u> | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<u>25223 Oak Drive</u> | |
| 10f. ZIP CODE
<u>20872</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>Teacher</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Catholic Schools</u> | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>John E. Howe</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Alexine McDonald</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Lawrence C. Kosowski</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>6824 Whistling Swan Way, New Market, MD 21774</u> | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Chesapeake Crematory</u> | | 20c. LOCATION — City or Town, State
<u>11-4 Beltsville, Maryland</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Elean H. Rapp</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910</u> | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. <u>Arteriosclerosis transcending cardiac death</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>Arteriosclerosis generalized</u>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>CVA, history cigarette heart failure, Euphyon seizures, Atrial fibrillation</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>William Joel Kordon MD</u> | | | | 29c. LICENSE NUMBER
<u>D06588</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>11/4/96</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>William Joel Kordon MD</u> | | | | 4801 Dorsey Hall Drive, #201
Ellicott City, MD 21042-7710 | | | |
| 31. DATE FILED (Month, Day, Year)
<u>NOV 06 1996</u> | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34796

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARGARET C. KANE | | | | 2. Date of Death
Month NOV Day 1 Year 1996 | | 3. Time of Death
6 40 AM | |
| | 4e. Facility Name (If not institution, give street and number)
Howard County General Hospital | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
577-22-9053 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
96 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 20, 1900 | |
| | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | 10a. State
N/A | | 10b. County
N/A | | 10c. City, Town or Location
Washington, D.C. | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
22 Eighth St.S.E. | | 10f. Zip Code
20003 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4or 5+) | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Information Officer | | | | 16b. Kind of Business/Industry
Federal Government | | 17. Father's Name (First, Middle, Last)
John Patrick Kane | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Breen | | | | 19a. Informant's Name/Relationship (Type, Print)
Matthew A. Kane, Esquire | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7910 Woodmont Avenue Bethesda, Maryland 20814 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cemetery | | 20c. Location - City or Town, State
11/04/96 Washington, D.C. | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Steven D. Stroud | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W. Silver Spring, MD 20901 | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):
b. Cerebral Artery Aneurysm
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
10/31/96
YEARS | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerosis, Diabetes | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
H. A. O'Connell | | 29c. License number
D31172 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
Nov 1 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
H. A. O'Connell 3460 Emory Court N 103 Emory City MD | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | 32. Registrar's Signature
John A. Randall | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

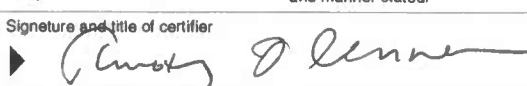

96 34797

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jeanette Miles LEONARD | | | | 2. Date of Death
Month Day Year
Nov. 1 1996 | | 3. Time of Death
5:55 p | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
204-16-0779 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug 15, 1926 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Talbot | | 10c. City, Town or Location
Royal Oak | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
Deep Neck Road | | 10f. Zip Code
21662 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
--- | | | |
| | 17. Father's Name (First, Middle, Last)
Russell T. Miles | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Hamill | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
J. Wade Leonard Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21611 Everlea Drive, Preston, Maryland 21655 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Capitol Crematory | | 20c. Location - City or Town, State
11/3/96 Dover, Delaware | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Harrison E. Leonard Funeral Home 21663
312 South Talbot Street, St. Michaels, Maryland | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Left Lower Lobe Pneumonia
Due to (or as a consequence of):
b. End Stage COPD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death
3 Days
1 Year | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Steroid Dependent
Coronary Artery Disease | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | | | |
| 29c. License number
D46763 | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
11/1/96 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Timothy J. Dennen, 607 Dutchmans Lane, Easton, Maryland, 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV - 7 1996 | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34798

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Alfred Daniel LANE, Sr.</i> | | | | 2. Date of Death
Month <i>November</i> Day <i>2</i> Year <i>1996</i> | | 3. Time of Death
<i>12:21 PM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Doctors Community Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Lanham</i> | | 4c. County of Death
<i>Prince Georges</i> | |
| Funeral
Director | 5. Social Security Number
<i>579-44-2593</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>62</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>July 31, 1934</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>Washington, D.C.</i> | | 10a. State
<i>Maryland</i> | | 10b. County
<i>Prince Georges</i> | | 10c. City, Town or Location
<i>Mitchellville</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
<i>3931 Sunflower Circle</i> | | 10f. Zip Code
<i>20721</i> | | 10g. Citizen of What Country?
<i>United States</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>Jan. 1958 - Jan. 1960</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Dental Technician</i> | | 16b. Kind of Business/Industry
<i>Veterans Administration Medical Center</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Gettys</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Viola May</i> | | 19a. Informant's Name/Relationship (Type, Print) (wife)
<i>Marion Elizabeth Love Lane</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3931 Sunflower Circle, Mitchellville, Maryland 20721</i> | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Quantico National Cemetery</i> | | 20c. Location - City or Town, State
<i>Quantico, Virginia</i> | | 21. Signature of Funeral Service Licensee
<i>Bonnie L. Smith</i> | |
| | 22. Name and Address of Facility
<i>Latney's Funeral Home, Inc.
3831 Georgia Avenue, N.W.; Washington, D.C. 20011</i> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <i>Heart Failure</i>
Due to (or as a consequence of):

b. <i>Coronary Artery Disease</i>
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | |
| Division of Vital Records, P.O. Box 68760, | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
<i>Nov. 8, 1996</i> | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Steven Remsen MD</i> | | 29c. License number
<i>D19446</i> | | 29d. Date signed (Month, Day, Year)
<i>11/4/96</i> | |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Steven Remsen, MD 8118 Good Luck Road, Lanham, MD 20706</i> | | 31. Date filed (Month, Day, Year)
<i>NOV 06 1996</i> | | 32. Registrar's Signature
<i>Jahia Anderson-Randall</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34799

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hannah Melissa Whitmire Livingston

2. Date of Death

Month Day Year

November 4, 1996

3. Time of Death

5:10 A. M.

4a. Facility Name (If not institution, give street and number)

12612 Tartan Lane

4b. City, Town, or Location of Death

Fort Washington Prince George's

4c. County of Death

Prince George's

5. Social Security Number

198-10-0915

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 17, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12612 Tartan Lane

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Nurses Aid

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Henry Whitmire

18. Mother's Name (First, Middle, Maiden Surname)

Bertha George

19a. Informant's Name/Relationship (Type, Print)

Dorothy Strunk/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12612 Tartan La. Ft. Washington, Md. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hanover Green Cemetery

Date

11-7-96

20c. Location - City or Town, State

Wilkes Barre, Pa.

21. Signature of Funeral Service Licensee

Robert P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC COLON CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 Mo.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:2 ☐ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert M. Nedzbal

29c. License number

D07348

29d. Date signed (Month, Day, Year)

Nov. 4, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert M. Nedzbal, M.D. 11701 Livingston Rd. #101, Ft. Washington, Md. 20744

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

John Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

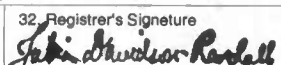
Certificate of Death

Reg. No.

96 34800

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT H. LLOYD | | | 2. Date of Death
Month OCT Day 30 Year 1996 | | 3. Time of Death
12:15 P | |
| | 4a. Facility Name (If not institution, give street and number)
7216 FLOWER AVE | | | 4b. City, Town, or Location of Death
TAKOMA PARK | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
209-28-4681 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
56 Yrs. | | 8. Date of Birth (Month, Day, Year)
9/11/40 |
| | 9. Birthplace (State or Foreign Country)
PITTSBURG, PA. | | | | | | |
| To Be Completed by Funeral Director | 10e. State
MD | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
TAKOMA PARK | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
7216 FLOWER AVENUE #10 | | | 10f. Zip Code
20912 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
AFRO-AMERICAN
Specify: |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 YEARS | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALESMAN | | 16b. Kind of Business/Industry
PRIVATE INDUSTRY |
| | 17. Father's Name (First, Middle, Last)
EDDIE LLOYD | | | 18. Mother's Name (First, Middle, Maiden Surname)
ALBERTA WATERS | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
LINDA BRABOY | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
660 NICHOLSON ST NE, DC 20011 | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Allegheny Cemetery | | Date
11/4/96 | | 20c. Location - City or Town, State
Pitts. Pa. |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
JOHN T. RHINES CO., INC.
3030 12TH ST NE, DC 20017 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NEPHROTIC SYNDROME
INSULIN DEPEND DIABETES
CHRONIC HEPATITIS | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
OCTOBER 31, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR J. L. LOCKE | | 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | | |
| 32. Registrar's Signature
 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34801

| | | | | | |
|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Willie LANDRUM</i> | | 2. Date of Death
Month <i>November</i> Day <i>2</i> Year <i>1996</i> | | 3. Time of Death
<i>11:15 AM</i> |
| | 4a. Facility Name (If not institution, give street and number)
<i>Southern Maryland Hospital</i> | | 4b. City, Town, or Location of Death
<i>Clinton</i> | | 4c. County of Death
<i>Prince George's</i> |
| Funeral
Director | 5. Social Security Number
<i>579-05-1789</i> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>82</i> Yrs. | 8. Date of Birth (Month, Day, Year)
<i>12/11/13</i> | 9. Birthplace (State or Foreign Country)
<i>EDGEFIELD, SC</i> |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>DC</i> | 10b. County
<i>N/A</i> | 10c. City, Town or Location
<i>WASHINGTON</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
<i>218 10TH STREET NE APT #2</i> | | 10f. Zip Code
<i>20002</i> | | 10g. Citizen of What Country?
<i>USA</i> |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify <i>NEGRO</i> |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>4TH GRADE</i>
College (1-4 or 5+) <i>NONE</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>TRUCK DRIVER</i> | | 16b. Kind of Business/Industry
<i>Private</i> |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<i>ROBERT LANDRUM</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>LYDIA SIMMONS</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>CYNTHIA D. HILL</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>843 20TH STREET NE, DC 20002</i> | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>LINCOLN CEMETERY</i> | | 20c. Location - City or Town, State
<i>11/8/96</i>
<i>SUITLAND, MD.</i> |
| | 21. Signature of Funeral Service Licensee
<i>Juan Smiller</i> | | 22. Name and Address of Facility
<i>JOHN T. RHINES CO., INC.</i>
<i>3030 12TH ST NE, DC 20017</i> | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Aspiration pneumonia</i>
Due to (or as a consequence of):

<i>b. Due to (or as a consequence of):</i>

<i>c. Due to (or as a consequence of):</i>

<i>d. Due to (or as a consequence of):</i> | | | | Approximate Interval Between Onset and Death
<i>days</i> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>chronic lymphocytic leukemia</i> | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>D19431</i> | | 29d. Date signed (Month, Day, Year)
<i>11/19/96</i> |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Franklin R. Adams, 11701 Livingston Rd #203, Ft. Washington, MD 20744</i> | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
<i>NOV 07 1996</i> | | 32. Registrar's Signature
<i>Jaki Davidson-Randall</i> | | |
| | | | | | |

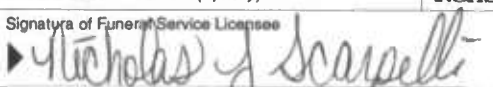
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34802

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kwong Y Lam | | | | 2. Date of Death
Month Nov Day 6 Year 1996 | | 3. Time of Death
11:25PM | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| Funeral
Director | 5. Social Security Number
075-72-2695 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
27 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 6. Date of Birth
(Month, Day, Year)
Mar 22, 1969 | 9. Birthplace (State or Foreign Country)
China |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
WV | | 10b. County
Mineral | | 10c. City, Town or Location
Ridgeley | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
Route 2 Box 40 | | | | 10f. Zip Code
26753 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Chinese | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Owner | | 16b. Kind of Business/Industry
Restaurant | | |
| 17. Father's Name (First, Middle, Last)
Ki Tin Lam | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Hung Ching (Ng) | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Simon Lam--brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 2 Box 40; Ridgeley WV 26753 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kensico Cemetery | | Date
11/13 | | 20c. Location - City or Town, State
Valhalla, NY | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Scarpelli Funeral Home for Cheung Sang F.H. Cumberland, MD 21502 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

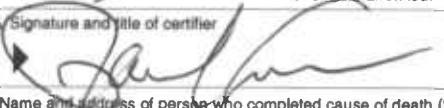

Immediate Cause (Final disease or condition resulting in death)

a. Extensive head trauma
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 hr |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
11/6/96 | | 28b. Time of Injury
10:45PM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Auto accident. Driver. auto flipped over |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Rt 28 W Va | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Rt 28 near Wiley Ford W Va | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier

Dpty Med Ex D 09157 | | | | 29c. License number
Nov 7 1996 | | 29d. Date signed (Month, Day, Year) | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Snow, M.D. 124 w 3rd st Cumb Md 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 12 1996 | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34803

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES HOYLE LYDDANE

2. Date of Death

Month Day Year
NOVEMBER 6, 1996

3. Time of Death

12:15 AM

4a. Facility Name (If not institution, give street and number)

MEDIPLEX OF MONTGOMERY VILLAGE

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577-05-3792

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 13, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19130 Club House Road

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Elmer E. Hoyle

18. Mother's Name (First, Middle, Maiden Surname)

Alda White

19a. Informant's Name/Relationship (Type, Print)

Ronald W. Lyddane, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9689 Dyerville Loop Rd., Myers Flat, CA 95554

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MONOCACY CEMETERY

Date

11/9/96

20c. Location - City or Town, State

Beallsville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

DEVOL FUNERAL HOME

10 EAST DEER PARK DRIVE, GAITHERSBURG, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic BLADDER CANCINOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accidents

HYPERTENSION

HEMIPARESIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

B30692

29d. Date signed (Month, Day, Year)

NOVEMBER 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gabriel A. Berrebi, M.D., 15200 Shady Grove Rd., #305 Rockville, MD 20850

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34804

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PHILLIP M. LIFSHUTZ

2. Date of Death

Month
NOV.Day
3,Year
1996

3. Time of Death

2:20 PM

4a. Facility Name (If not Institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

090-09-7615

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
NOV. 19, 1914

9. Birthplace (State or Foreign Country)

TEXAS

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1001 SPRING ST. #420

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

RET. - SALESMAN

16b. Kind of Business/Industry

LIQUOR STORE

17. Father's Name (First, Middle, Last)

ABRAHAM LIFSHUTZ

18. Mother's Name (First, Middle, Maiden Summa)

KATIE FREED

19a. Informant's Name/Relationship (Type, Print)

PAMELA A. PAULACONIS/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1019 WEST COAL ST., SHENANDOAH, PA., 17976

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

11/5

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

YRS.

b. ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

YRS.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE HEART DISEASE

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐
☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D28920

29d. Date signed (Month, Day, Year)

NOV. 3, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SURINDER SINGH M.D.

7319A HANOVER PARKWAY, GREENBELT, MD. 20770

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes the need for transparency and accountability in financial reporting.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It includes a detailed description of the experimental procedures and the statistical analysis performed.

3. The third part of the document presents the results of the study. It includes a series of tables and graphs that illustrate the findings of the research. The data shows a clear trend of increasing activity over time.

4. The fourth part of the document discusses the implications of the findings. It suggests that the results of the study have significant implications for the field of research and may lead to further developments in the future.

5. The fifth part of the document concludes the study and provides a summary of the key findings. It also includes a list of references to the literature cited throughout the document.

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State of Maryland / Department of Health and Mental Hygiene

96 34805

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Herndon Listman

2. Date of Death

Nov 3 1996

3. Time of Death

2:25pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

212-34-2327

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 8, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

9907 Edgehill Lane

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

John H. Trainor, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Alice M. Shields

19a. Informant's Name/Relationship (Type, Print)

Vernon Trainor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9907 Edgehill Lane, Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

crematory, crematory or other place)

Metropolitan Crematory

Date

11/6/96

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

James E. Dooley

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd. West

Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Septic

Due to (or as a consequence of):

days

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert W. H. H. H.

29c. License number

D47215

29d. Date signed (Month, Day, Year)

11/5/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1106 Spring Street Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34806

2 1/1

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUCILLE

MATTHEWS

2. Date of Death

NOVEMBER 1 1996

3. Time of Death

2:20 AM

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

579-38-9973

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr 30, 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1925 Brooks Drive

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Home

17. Father's Name (First, Middle, Last)

Kenneth Tapley

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Wilson

19a. Informant's Name/Relationship (Type, Print)

Barbara Matthews (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1925 Brooks Drive, Forestville, Md. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Nat Park

Date

11/6/96

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

M859

22. Name and Address of Facility

Alexander S. Pope Funeral Homes
5538 Marlboro Pike, Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Artery

Approximate Interval Between Onset and Death

few hr

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
Acute myocardial infarction

few hr

Due to (or as a consequence of):
Coronary atherosclerosis

years

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Melastatic breast carcinoma, Acute hepatic failure, Metabolic acidosis, Anaemia
Chronic renal insufficiency.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24720

29d. Date signed (Month, Day, Year)

NOVEMBER 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVINDER RUSTAGI 6132 LANDOVER ROAD CHEVERLY MD 20785

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SAMUEL MAPSON JR.

2. Date of Death
Month Day Year
NOVEMBER 5, 19963. Time of Death
04:42 AM
FOUND

4a. Facility Name (If not institution, give street and number)

1104 Nova Ave.

4b. City, Town, or Location of Death

CAPITOL HEIGHTS

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

227-38-0259

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

62 64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/3/32
(Month, Day, Year)
APRIL 25, 1934

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

XX Yes 20 No

10e. Street and Number

1104 NOVA AVE. 608 63rd Place

10f. Zip Code

20743

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

10 Never Married 20 Married

30 Widowed XX Divorced

12. Was Decedent Ever in U.S.

XX Yes 20 No

If Yes, Give Year or Dates: 1958-1962

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes XX No Specify: N/A

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

GED

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

DEPT. OF COMMERCE

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

SAMUEL MAPSON, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE P. GARY DUNN

19a. Informant's Name/Relationship (Type, Print)

MATTIE P. DUNN/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

529 1/2 9TH ST. N.E., WASHINGTON, D.C. 20002

20a. Method of Disposition

XX Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND ST. VETERANS CEM. 11-12-96 CHELTENHAM, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward M. Dudley

EDWARD M. DUDLEY

22. Name and Address of Facility

DUDLEY FUNERAL HOME

3200 RHODE ISLAND AVE., MT. RAINIER, MARYLAND

23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably XX Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

28. Place of Death (Check only one)

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural

50 Pending Investigation

20 Accident

60 Could not be determined

30 Suicide

40 Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mario F. Golie Jr.

29c. License number

PERMITS MEDICAL EXAMINER
D 33354

29d. Date signed (Month, Day, Year)

NOVEMBER 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLIE JR., M.D. 3501 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

John Anderson Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34808

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia L. Mertens

2. Date of Death

Month Day Year
October 31, 1996

3. Time of Death

10:55 pm

4e. Facility Name (If not institution, give street and number)

5010 69th Place

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-12-1174

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

September 19, 1920 Pennsylvania

9. Birthplace (State or Foreign Country)

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5010 69th Place

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Benjamin Nicol

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Elizabeth Shoemaker

19a. Informant's Name/Relationship (Type, Print)

Fritz W. Mertens-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5010 69th Place, Hyattsville, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Washington National Cem.

Date

11/4/96

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

► Claudette J. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Ave. Hyattsville, Md. 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. premonitory and gradual debility

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. multiple infarcts, coronary artery disease

Due to (or as a consequence of):

c. Breast cancer

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic heart disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

► James W. Harding MD

29c. License number

DO 5401

29d. Date signed (Month, Day, Year)

November 1, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James W. Harding, M.D. 7525 Greenway Center Drive #316, Greenbelt, MD 20770-3525

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

Julia Anderson-Rodell

State
Registrar

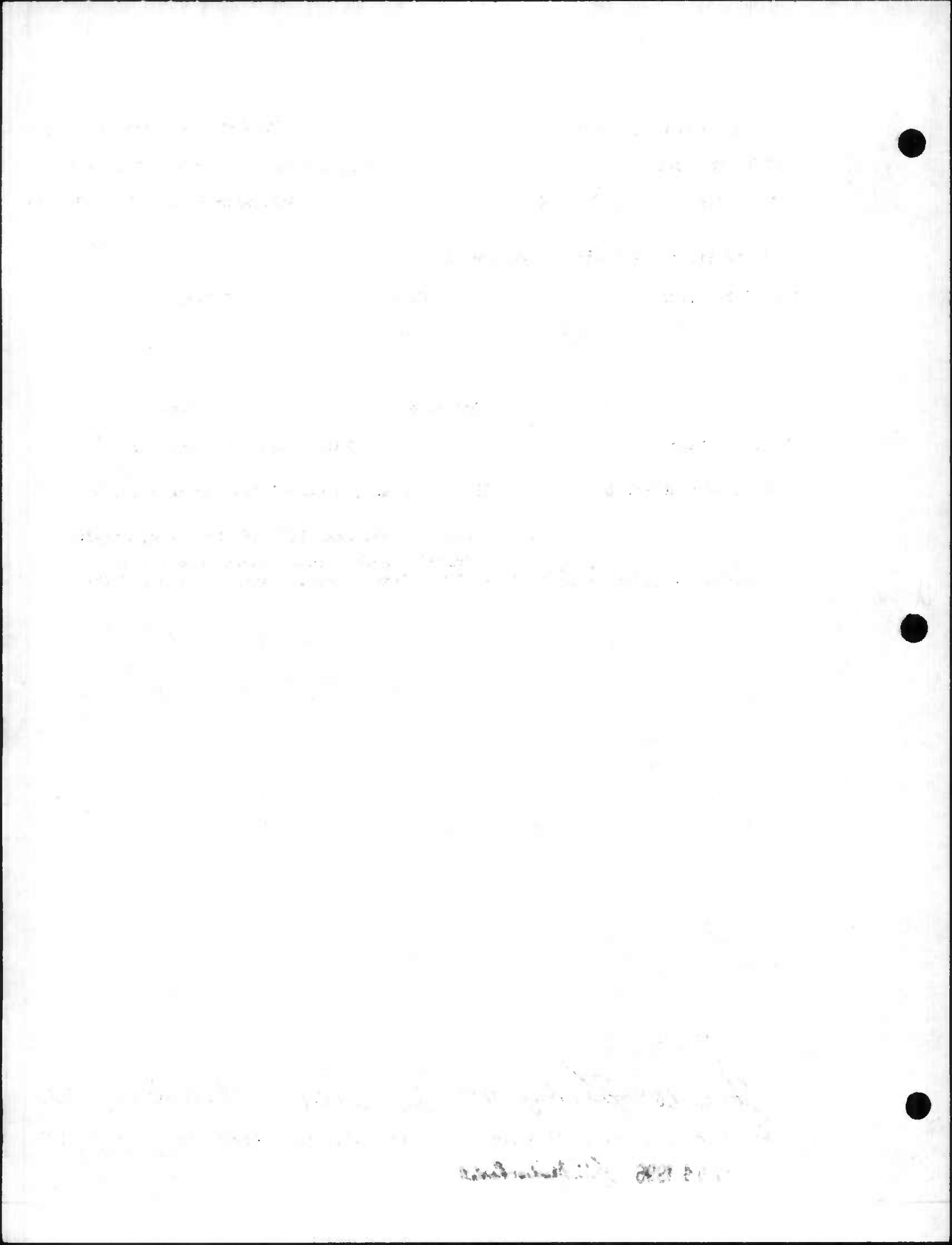
Baltimore, Maryland 21215-0020

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any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34809

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Luella Russell Miller

2. Date of Death

November 2, 1996

3. Time of Death

10:27 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-42-1846

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

8. Date of Birth

(Month, Day, Year)

July 10, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8505 Springvale Road

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Book Keeping

16b. Kind of Business/Industry

Frozen Food Company

17. Father's Name (First, Middle, Last)

John Keyser

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Williams

19a. Informant's Name/Relationship (Type, Print)

Mary Luella Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12523 Masters Ridge Drive Jacksonville FL 32225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Crematory

Date

11/6/96 Brentwood, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Luisa Butierrez

22. Name and Address of Facility

Fort Lincoln Funeral Home, Inc.

3401 Bladensburg Rd, Brentwood Md 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Interstitial Pneumonia

Due to (or as a consequence of):

b. Spontaneous

Due to (or as a consequence of):

c. Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

10 days

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Idiopathic Aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Luisa Butierrez

29c. License number

D06959

29d. Date signed (Month, Day, Year)

Nov 2, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

EUBA J. MARTINEZ MD

8808 Hidden Hill Lane, Potomac, MD 20854

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34810

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lida Watters MacLean

2. Date of Death

October 24 1996

3. Time of Death

0745

4e. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

213-48-9359

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 6, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13 Shamrock Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
if Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alex Young Watters

18. Mother's Name (First, Middle, Maiden Surname)

Hattie (unknown) Wisdom

19a. Informant's Name/Relationship (Type, Print)

Donald H. MacLean - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Shamrock Road, Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fallston U.M. Church Cem.

Date

10/28/96

20c. Location - City or Town, State

Fallston, Md.

21. Signature of Funeral Service Licensee

Stephen A. Murphy

22. Name and Address of Facility

Howard K. McComas III Funeral Home. P.A.
50 W. Broadway, Bel Air, Md. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Age pneumonia

b. Due to (or as a consequence of):

H. P. blood

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Card

- HPA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. Randall MD

29c. License number

042800

29d. Date signed (Month, Day, Year)

10/24/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donald H. MacLean, 3195 Union Ave, H&B, MD 21078

31. Date filed (Month, Day, Year)

OCT 28 1996

32. Registrar's Signature

John Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34811

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES MESSICK | | | | 2. Date of Death
Month Oct Day 31 Year 1996 | | 3. Time of Death
7:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Calvert Manor Healthcare Center | | | | 4b. City, Town, or Location of Death
Rising Sun | | 4c. County of Death
Cecil | |
| Funeral
Director | 5. Social Security Number
216-14-4133 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
2/14/1906 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Harford | | 10c. City, Town or Location
Street Dublin Road | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3028 Dublin Road | | 10f. Zip Code
21154 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
Civil Service | | 17. Father's Name (First, Middle, Last)
Unknown | | |
| 17. Mother's Name (First, Middle, Maiden Summa)
Unknown | | 19a. Informant's Name/Relationship (Type, Print)
Donald G. McCullough, Jr. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1984 Lancaster Pike Peach Bottom, PA 17563 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dublin Southern Cem. | | 20c. Location - City or Town, State
11/2 Darlington, MD | | 21. Signature of Funeral Service Licensee
<i>Jeffrey P. Lovelidge</i> | | 22. Name and Address of Facility
Harkins Funeral Home, Inc., Delta, PA | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Congestive Heart Failure
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
1 day | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | b. Hypertensive Aortic
Due to (or as a consequence of): | | 10 yrs | | | | |
| | | c. peptic ulcer disease & bleeding
Due to (or as a consequence of): | | 3 yrs | | | | |
| | | d. Diabetes | | 20 yrs | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Malcolm Dudley Phillips, M.D.</i> | | 29c. License number
D09482 | | 29d. Date signed (Month, Day, Year) | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Malcolm Dudley Phillips, M.D., Darlington, MD 21034 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 4 1996 | | 32. Registrar's Signature
<i>Douglas Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings and their implications for the field of research.

4. The fourth part of the report is a conclusion and a discussion of the limitations of the study. It also includes a list of references and a list of figures and tables.

5. The fifth part of the report is a list of references and a list of figures and tables.

6. The sixth part of the report is a list of references and a list of figures and tables.

7. The seventh part of the report is a list of references and a list of figures and tables.

8. The eighth part of the report is a list of references and a list of figures and tables.

9. The ninth part of the report is a list of references and a list of figures and tables.

10. The tenth part of the report is a list of references and a list of figures and tables.

11. The eleventh part of the report is a list of references and a list of figures and tables.

12. The twelfth part of the report is a list of references and a list of figures and tables.

13. The thirteenth part of the report is a list of references and a list of figures and tables.

14. The fourteenth part of the report is a list of references and a list of figures and tables.

15. The fifteenth part of the report is a list of references and a list of figures and tables.

16. The sixteenth part of the report is a list of references and a list of figures and tables.

17. The seventeenth part of the report is a list of references and a list of figures and tables.

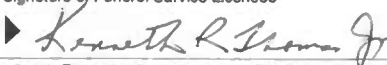
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

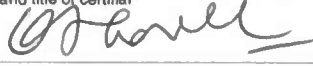
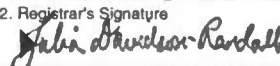
96 34812

| | | | | | | | | |
|---|--|---|--|-------------------------------------|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT ELWOOD MELVIN | | | | 2. Date of Death
Month November Day 8 Year 1996 | | 3. Time of Death
0630 | |
| | 4a. Facility Name (If not Institution, give street and number)
Mallard Bay Center | | | | 4b. City, Town, or Location of Death
Cambridge | | 4c. County of Death
Dorchester | |
| Funeral
Director | 5. Social Security Number
213-14-1817 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 27 1921 | |
| | 9. Birthplace (State or Foreign Country)
Delaware | | 10a. State
MD | | 10b. County
Dorchester | | 10c. City, Town or Location
Cambridge | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
414 Edlon Park | | 10f. Zip Code
21613 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1942-1971 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
U.S. Air Force | | 16b. Kind of Business/Industry
military | | | |
| | 17. Father's Name (First, Middle, Last)
Roy S. Melvin | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Louise Adonia Todd | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Pat Melvin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
414 Edlon Park, Cambridge MD 21613 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dorchester Memorial Park | | 20c. Location - City or Town, State
Cambridge Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Thomas Funeral Home PA
700 Locust St. Cambridge MD 21613 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA OF THE LUNG
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | | | | | | Approximate Interval Between Onset and Death
SEVERAL YEARS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D1565 | | 29d. Date signed (Month, Day, Year)
11/8/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M.S. Shariff, M.D. 105 Aurora Street Cambridge, MD 21613 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 12 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 34813

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELIZABETH K. MILLS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Nov 10, 1996 | | 3. TIME OF DEATH
3:25 AM | |
| 4. SOCIAL SECURITY NUMBER
218-34-4445 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
99 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct 30, 1897 | |
| 8. BIRTHPLACE (State or Foreign Country)
PA | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
ALLEGANY COUNTY NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Cumberland | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
135 N. Mechanic Street | | | | 10f. ZIP CODE
21502 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Self-employed | | 16b. KIND OF BUSINESS/INDUSTRY
Housekeeping | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles T. Williams | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Tressea E. (Howarth) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Alice Golden | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 1 Box 52; Wiley Ford, WV 26767 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Queens-Meadow Point Cem 11/12 Keyser, WV | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Nicholas J. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. HYPERTENSIVE CARDIOVASCULAR DISEASE 20 YRS
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MULTIFARCT DEMENTIA
RECURRENT CVA
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Robustiano Barrera</i> | | 29c. LICENSE NUMBER
D14865 | | 29d. DATE SIGNED (Month, Day, Year)
Nov 11, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Robustiano Barrera; Memorial Hospital Med. Bldg; Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 12 1996 | | 32. REGISTRAR'S SIGNATURE
<i>Jane Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5
not

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34814

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lani E. Miles

2. Date of Death

November 1, 1996

3. Time of Death

5:25 P.

4a. Facility Name (If not institution, give street and number)

2906 Miles Road

4b. City, Town, or Location of Death

Burtonsville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

215-38-4526

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 21, 1941

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Burtonsville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

2906 Miles Road

10f. Zip Code

20866

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cafeteria worker

16b. Kind of Business/Industry

Montgomery County

Public Schools

17. Father's Name (First, Middle, Last)

Charles

Howe

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Duval

19a. Informant's Name/Relationship (Type, Print)

Raymond Miles (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Union Cemetery

Date

11/4/1996

20c. Location - City or Town, State

Burtonsville, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory failure

Due to (or as a consequence of):

Renal failure

Due to (or as a consequence of):

Amyloidosis

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Sudden

2 Months

2 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

Seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suresh Kumar Gupta

29c. License number

D-32332

29d. Date signed (Month, Day, Year)

November 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Kumar Gupta, M.D. 9801 Georgia Avenue Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

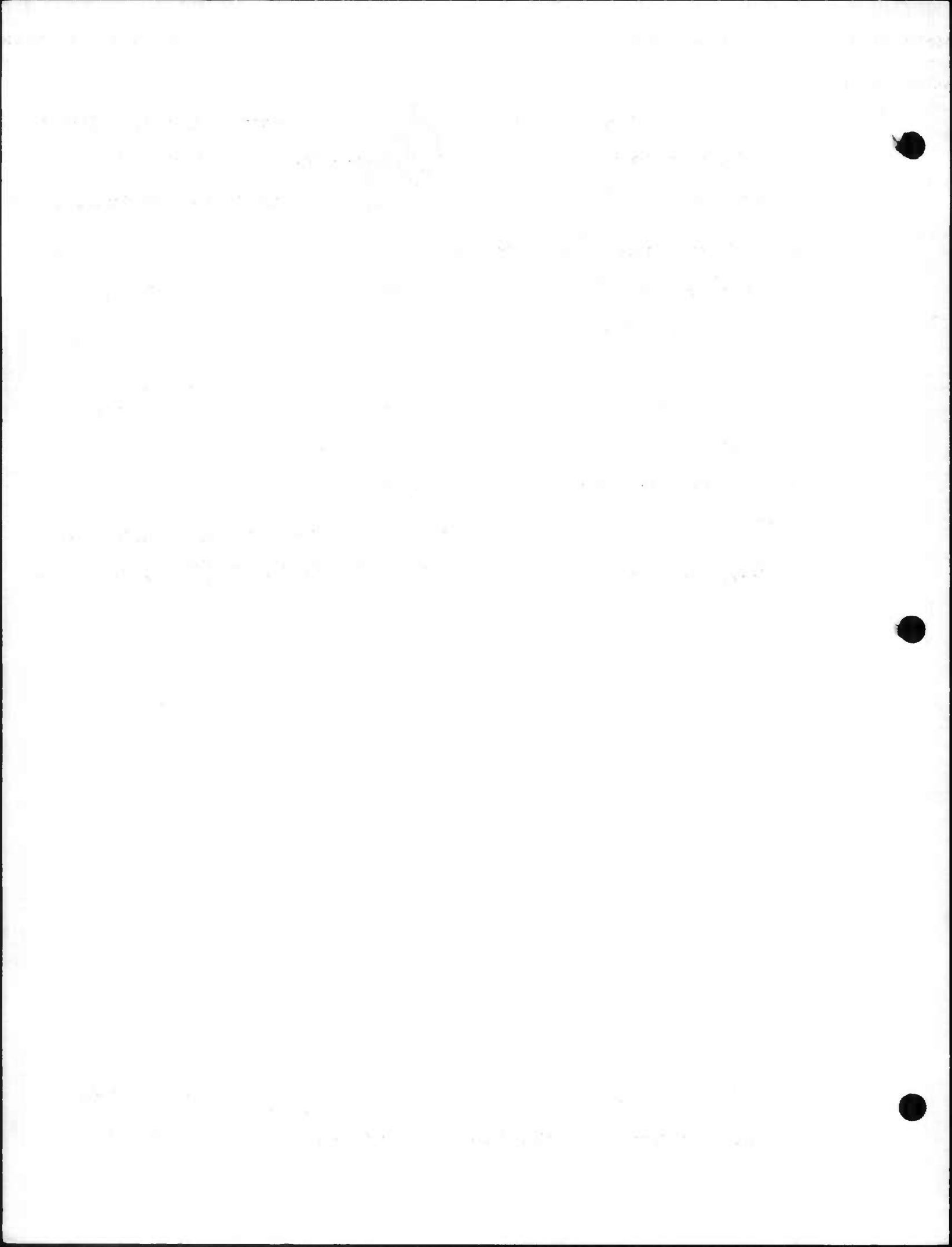
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34815

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)
ELLEN MARIE | | 2. Date of Death
Month OCTOBER Day 30 Year 1996 | | 3. Time of Death
00:50 AM |
| 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | 4b. City, Town, or Location of Death
CLINTON | | 4c. County of Death
PRINCE GEORGES |
| 5. Social Security Number
215-76-7591 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | 8. Date of Birth (Month, Day, Year)
MAR. 17, 1929 | 9. Birthplace (State or Foreign Country)
Korea |

| | | | | |
|-------------------------------|--------------------------------------|-----------------------------|--|--|
| Usual Residence of Decedent | | 10c. City, Town or Location | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. State
Maryland | 10b. County
Prince Georges | Fort Washington | | |

| | | | |
|--|--|-------------------------------|---|
| 10e. Street and Number
12316 Hatton Point Road | | 10f. Zip Code
20744 | 10g. Citizen of What Country?
USA |
|--|--|-------------------------------|---|

| | | | | |
|--|--|---|--|---|
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.
Specify: Asian |
|--|--|---|--|---|

| | | | |
|--|--|---|---|
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | 16b. Kind of Business/Industry
Own Home |
|--|--|---|---|

| | | | |
|--|--|--|--|
| 17. Father's Name (First, Middle, Last)
Sung Jae Yim | | 18. Mother's Name (First, Middle, Maiden Surname)
Sook Kyung Kim | |
|--|--|--|--|

| | | | |
|---|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print)
Peter W. Yim / Brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12316 Hatton Point Road, Fort Washington, MD 20744 | |
|---|--|--|--|

| | | | | |
|---|--|--|------------------------|---|
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Norbeck Memorial Park | Date
11/1/96 | 20c. Location - City or Town, State
Olney, Maryland |
|---|--|--|------------------------|---|

| | | | |
|---|--|--|--|
| 21. Signature of Funeral Service Licensee
Lane J. Holland | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | |
|---|--|--|--|

| | | |
|--|--|--|
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | Approximate Interval Between Onset and Death |
| a. Acute and severe myocardial infarction
Due to (or as a consequence of): | | days |
| b. Severe atherosclerotic coronary heart disease
Due to (or as a consequence of): | | years |
| c. intractable congestive heart failure.
Due to (or as a consequence of): | | days |
| d. Diabetes mellitus, type II. | | Years |

| | | | |
|---|--|--|---|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Adenocarcinoma of rectum with massive G.I. bleeding history. left side hemiparesis with ischemic stroke. hypertensive cardiovascular disease with cardiomegaly major depression. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | |
|---|--|---|-----------------------------------|
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | |
|---|--|
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
|---|--|

| | | | |
|---|--|--------------------------------------|--|
| 29b. Signature and title of certifier
Peter W. Yim M.D. | | 29c. License number
D12884 | 29d. Date signed (Month, Day, Year)
Oct. 30 1996 |
|---|--|--------------------------------------|--|

| | |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PETER W YIM M.D. 7900 OLD BRANCH AVE SUITE 101, CLINTON, MARYLAND 20735 | |
|--|--|

| | |
|---|--|
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | 32. Registrar's Signature
Julia Davidson-Rendell |
|---|--|

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34816

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Langston Merkle

2. Date of Death

Month Day Year
November 7, 1996

3. Time of Death

12:40 AM

4a. Facility Name (If not Institution, give street and number)

Mediplex of Montgomery Village

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

577-09-1831

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 24, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9507 Briar Glen Way

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (14 or 5+)
12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

John W. Merkle

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Waycaster

19a. Informant's Name/Relationship (Type, Print)

Frances M. Merkle, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9507 Briar Glen Way, Gaithersburg, MD 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Norbeck Memorial Park

Date

Nov. 11, 1996

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular accident

Approximate Interval Between Onset and Death

Hours

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
Multi-infarct dementia

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

B30692

29d. Date signed (Month, Day, Year)

November 8, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gabriel A. Berrebi, M.D., 15200 Shady Grove Rd., #305 Rockville, MD 20850

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34817

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Yvette R. Medlar

2. Date of Death

Month Day Year
November 5, 1996

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

Mariner Nursing Home

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

008-03-6887

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 12, 1914

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

3618 Littledale Road

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retail Manager

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Toussaint Robert

18. Mother's Name (First, Middle, Maiden Surname)

Albina Giroux

19a. Informant's Name/Relationship (Type, Print)

Patricia C. Webster

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 Hermleigh Road Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

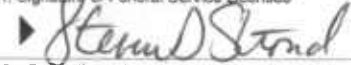
20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 11/09/96 Silver Spring, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Dehydration

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 09834

29d. Date signed (Month, Day, Year)

November 5, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Barry Rosenbaum 3720 Farragut Avenue Kensington, Maryland 20895

State
Registrar

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34818

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Stephen McAuliffe

2. Date of Death

Month Day Year
October 31, 1996

3. Time of Death

1:55AM

4a. Facility Name (If not institution, give street and number)

7200 Old Stage Road

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-44-9852

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 16, 1907

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7200 Old Stage Road

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Chief of Police

16b. Kind of Business/Industry

Montgomery County

17. Father's Name (First, Middle, Last)

John Dennis McAuliffe

18. Mother's Name (First, Middle, Maiden Surname)

Mary Catherine O'Connor

19a. Informant's Name/Relationship (Type, Print)

Ida Claudia McAuliffe/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7200 Old Stage Road, Rockville, Maryland 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)November 4, 1996
Monocacy Cemetery

Data

20c. Location - City or Town, State

Beallsville, Maryland

21. Signature of Funeral Service Licensee

Barbara J. McMullen-Lukens
M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

15 Minutes

b. Atrial Fibrillation

Due to (or as a consequence of):

4 Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Polycythemia

S/P Cerebral Thrombosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Eugene P. Libre

29c. License number

D09470

29d. Date signed (Month, Day, Year)

October 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene P. Libre, M.D. 10400 Connecticut Avenue, Kensington, MD 20895

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

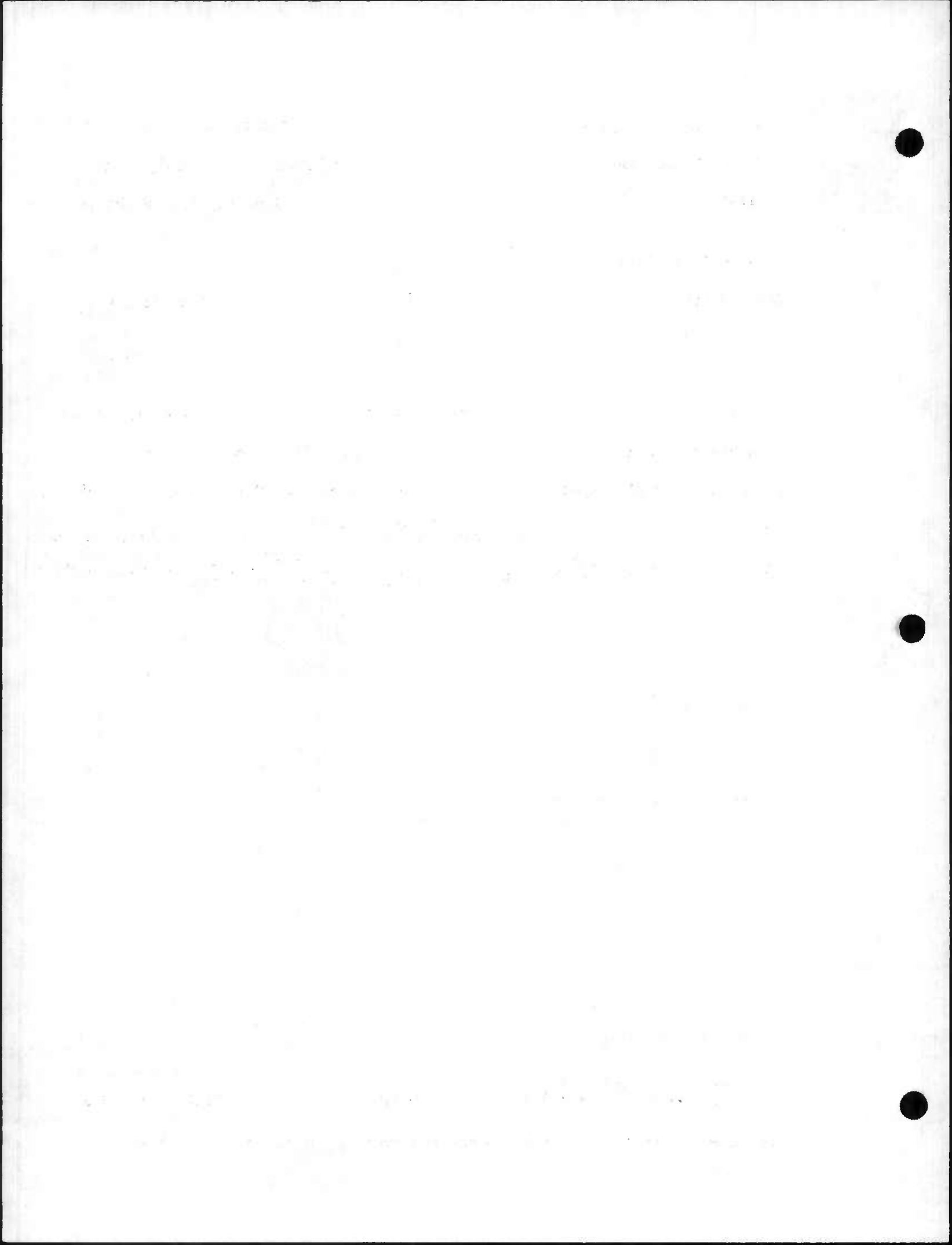
Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34819

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Arthur T. Mullett | | | | 2. Date of Death
Month NOVEMBER Day 1 Year 1996 | | 3. Time of Death
2:05PM | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
114-14-1667 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 23, 1927 | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
MD. | | 10b. County
Montgomery | | 10c. City, Town or Location
Chevy Chase | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
3943 Newdale Rd. Apt. 1141 | | 10f. Zip Code
20815 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 11/3/44 - 10/14/48 | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4or 5+) | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Administrator | | | | 16b. Kind of Business/Industry
Hospital | | 17. Father's Name (First, Middle, Last)
George Mullett | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Fletcher | | | | 19a. Informant's Name/Relationship (Type, Print)
Nancy C. Mullett | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3943 Newdale Rd. Apt. 1141 Chevy Chase, MD. 20815 | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chambers Crematory | | 20c. Location - City or Town, State
11/8/96 Riverdale, MD. | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<i>Thomas S. Chambers</i> # 610 | | | | 22. Name and Address of Facility
W.W. Chambers Co. Inc.
5801 Cleveland Ave. Riverdale, MD. 20737 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. myocardial infarction
Due to (or as a consequence of):
b. Aspiration Pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | Approximate interval between Onset and Death
48 hrs.
48 hours | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year)
11/3/96 | | | | 28b. Time of Injury
M | | | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>Arthur T. Mullett</i> | | | |
| | 29c. License number
D37891 | | | | 29d. Date signed (Month, Day, Year)
NOVEMBER 1 1996 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ARATVARY SITI MD 121 Congressional Ln # 409 Rockville, MD 20852 | | | | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | | |
| | 32. Registrar's Signature
<i>Lia Davidson-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1942-1943

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State of Maryland / Department of Health and Mental Hygiene

96 34820

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel Martin Mackey

2. Date of Death

Month Day Year
November 3, 1996

3. Time of Death

4:43 AM

4a. Facility Name (If not institution, give street and number)

10022 Stedwick Road, #104

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

055-12-9152

6. Sex

1 ☐ M 2 ☐ F
1 ☒ M

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 4, 1918

9. Birthplace (State or Foreign Country)

New York, NY.

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10022 Stedwick Road #104

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1941
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: to 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personnel Director

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Daniel Martin Mackey

18. Mother's Name (First, Middle, Maiden Surname)

Mary Walter

19a. Informant's Name/Relationship (Type, Print)

Kathleen H. Mackey (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10022 Stedwick Rd. #104 Gaithersburg, Md. 20879

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Nov. 4 1996

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Restrictive Lung Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cor Pulmonale

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carl I. Schoenberger 16220 Frederick Rd Gaithersburg Md

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34821

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHESTER V. MOWEL

2. Date of Death

Month Day Year
NOV. 3, 1996

3. Time of Death

11:57 PM

4a. Facility Name (If not institution, give street and number)

PLEASANT VIEW NURSING HOME

4b. City, Town, or Location of Death

MOUNT AIRY

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

220-32-6002

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 27, 1936

9. Birthplace (State or Foreign Country)

TENN.

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

MT. AIRY

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

4101 OLD NATIONAL PIKE

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ASPHALT PAVER

16b. Kind of Business/Industry

PAVING CO.

17. Father's Name (First, Middle, Last)

OSCAR W. MOWEL

18. Mother's Name (First, Middle, Maiden Surname)

SYLVIA V. SMITH

19e. Informant's Name/Relationship (Type, Print)

DONNA BARTH/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 SEBASTIANI BLVD., GAITHERSBURG, MD. 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHAMBERS CREMATORY

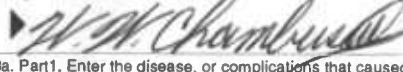
Date

11/6

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee



M00091

22. Name and Address of Facility

SILVER SPRING, MD.

W. W. CHAMBERS CO. INC.

20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Respiratory Decompensation.

Due to (or as a consequence of):

b. Severe Hypoxemia.

Due to (or as a consequence of):

c. Peripheral Cyanosis.

Due to (or as a consequence of):

d. End-stage Pulmonary Disease.

Approximate
Interval Between
Onset and DeathOne hour
and Twenty
minutes.
EXPIRED 11:57
PM, 11/3/96.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 M.D.

29c. License number

D-40201

29d. Date signed (Month, Day, Year)

11-4-96

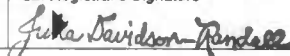
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARZAD ASSAR, M.D. / 1502 S. MAIN ST., MT AIRY, MD 21771

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2002

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11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34822

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|--|--|---------------------------|---|--|--|--|--|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JUANA MIROCZNIK | | | | 2. Date of Death
Month Day Year
NOV. 1, 1996 | | 3. Time of Death
4:45 AM | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
MEDLANTIC NURSING HOME | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY | | | | | | | | |
| Funeral
Director | 5. Social Security Number
579-13-7940 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth
Month Day Year
JULY 18, 1920 | | 9. Birthplace (State or Foreign Country)
POLAND | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
SILVER SPRING | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
3520 PEAR TREE COURT #24 | | | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
UNITED STATES | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
OWN HOME | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
JACOB RADOSZYCKI | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ADELA PROSCAULR-KREPS | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
HIRSH WOLF MIROCZNIK (HUSBAND) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3520 PEAR TREE COURT #24 - SILVER SPRING, MD. 20906 | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESED SHEL EMMES CEM. | | Date
11/3/96 | | 20c. Location - City or Town, State
WASHINGTON, D.C. | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Kathleen Broenne</i> | | | | | 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>PNEUMONIA</i>
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
<i>One week</i> | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Cerebro Vascular Accident</i>
<i>CORONARY DISEASE</i> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier
<i>Rafael A. Mathews</i> | | 29c. License number
D-18924 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 1ST 96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAFAEL A. MATHEWS, MD. 13018 GEORGIA AVE. WHEATON, MD 20906 | | | | | | | | | | 31. Date filed (Month, Day, Year)
NOV 07 1996 | | 32. Registrar's Signature
<i>Rita Davidson-Randall</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician
/Medical
ExaminerState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34823

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William T. Mills

2. Date of Death

Month

Day

Year

10

30

96

3. Time of Death

2:30

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST NURSING CENTER

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577.01.1600

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

APRIL 17, 1908

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9701 MEDICAL CENTER DRIVE

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SUPERVISOR C&P

SWITCHBOARD OPERATOR

16b. Kind of Business/Industry

C & P TELEPHONE CO.

17. Father's Name (First, Middle, Last)

EDWARD THEODORE BROOKE

18. Mother's Name (First, Middle, Maiden Surname)

HENRIETTA FREDERICKA OTTO

19a. Informant's Name/Relationship (Type, Print)

JOSEPH E. MILLS, III

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36 JINELLA COURT BOONTON, N.J. 07005

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Date

11/4/96

20c. Location - City or Town, State

SILVER SPRING, MD.

21. Signature of Funeral Service Licensee

John F. Gustafson

22. Name and Address of Facility

JOSEPH GAWLER'S SONS

5130 WI AVE NW WASHINGTON DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

Approximate

Interval Between

Onset and Death

5 days

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cerebrovascular

Disease with Multi Infarct

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

John F. Gustafson, MD

29c. License number

D15049

29d. Date signed (Month, Day, Year)

October 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Gustafson, M.D. 5480 Wisconsin Avenue Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

a. Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34824

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|---|---|--|---|---|--|--|---|---|--|---------------------|---------------|--|--|---|--|--|--|--|--|---------------------------------|--|--|--|-----------------------------------|--|---|--|--|--|--------------------------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elvira C. Mendez | | | | | | 2. Date of Death
Month Day Year
November 4, 1996 | | 3. Time of Death
7:30 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Montgomery General Hospital | | | | | | 4b. City, Town, or Location of Death
Olney | | 4c. County of Death
Montgomery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
N/A | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 23, 1910 | | 9. Birthplace (State or Foreign Country)
Sausal, Peru | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Laytonsville | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
20804 Layton Ridge Drive | | | | 10f. Zip Code
20882 | | 10g. Citizen of What Country?
Peru | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify:
Peruvian | | | 14. Race - American Indian, Black, White, etc.
Specify:
Peru | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Obdulio Conrejo | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Josefa Guerrero | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Maximo Pierola | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20804 Layton Ridge Drive Laytonsville, Maryland 20882 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Park | | | Date
11/07/96 | | 20c. Location - City or Town, State
Rockville, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
William L. Byrd | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W. Silver Spring, MD 20901 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Respiratory Failure</td> <td>Approximate Interval Between Onset and Death
4 hours</td> </tr> <tr> <td>b. Pneumonia</td> <td>24 hrs</td> </tr> <tr> <td>c. Stroke</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Failure | Approximate Interval Between Onset and Death
4 hours | b. Pneumonia | 24 hrs | c. Stroke | | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Failure | Approximate Interval Between Onset and Death
4 hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. Pneumonia | 24 hrs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | c. Stroke | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="6">23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="8">26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury
M</td> <td colspan="2">28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2">29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> <td colspan="2">29b. Signature and title of certifier
Harold Reilly MD PhD</td> <td colspan="2">29c. License number
D39190</td> <td colspan="4">29d. Date signed (Month, Day, Year)
November 5 1996</td> </tr> <tr> <td colspan="10">30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Garrett Reilly, M.D. 11510 Old Georgetown Road Rockville, Maryland 20852</td> </tr> <tr> <td colspan="10">31. Date filed (Month, Day, Year)
NOV 07 1996</td> </tr> <tr> <td colspan="10">32. Registrar's Signature
J. Davidson-Randall</td> </tr> </table> | | | | | | | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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D39190 | | 29d. Date signed (Month, Day, Year)
November 5 1996 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
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NOV 07 1996 | | | | | | | | | | 32. Registrar's Signature
J. Davidson-Randall | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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Harold Reilly MD PhD | | 29c. License number
D39190 | | 29d. Date signed (Month, Day, Year)
November 5 1996 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Garrett Reilly, M.D. 11510 Old Georgetown Road Rockville, Maryland 20852 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
J. Davidson-Randall | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

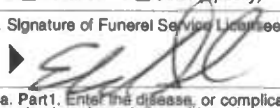
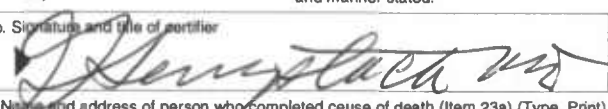
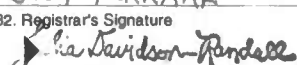
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34825

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|-----------------------------------|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Otto Menkes | | | | 2. Date of Death
Month Day Year
Nov 5, 1996 | | 3. Time of Death
7:30 A.M. | |
| | 4a. Facility Name (If not Institution, give street and number)
Althea Woodland Nursing Home | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
577-24-1999 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 14, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Poland | | 10a. State
Md. | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
10301 Grosvenor Place #2007 | | | | 10f. Zip Code
20852 | | 10g. Citizen of What Country?
US | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Accountant | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
Ludwig Menkes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosa Goldberger | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Judith Menkes | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10301 Grosvenor Pl #2007 Rockville MD 20852 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Memorial Gardens 11/8 Falls Church, VA | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Edward Sagel Funeral Direction
1091 Rockville Pike Rockville MD 20852 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Alzheimer's Disease | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death
10 yrs | | | | | | | |
| Physician
/Medical
Examiner | 23a. Immediate Cause (Final disease or condition resulting in death)
Alzheimer's Disease | | | | | | | |
| | 23b. Due to (or as a consequence of): | | | | | | | |
| | 23c. Due to (or as a consequence of): | | | | | | | |
| | 23d. Due to (or as a consequence of): | | | | | | | |
| | 23e. Due to (or as a consequence of): | | | | | | | |
| | 23f. Due to (or as a consequence of): | | | | | | | |
| | 23g. Due to (or as a consequence of): | | | | | | | |
| | 23h. Due to (or as a consequence of): | | | | | | | |
| | 23i. Due to (or as a consequence of): | | | | | | | |
| | 23j. Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and Title of Certifier
 | | | | 29c. License number
D12121 | | 29d. Date signed (Month, Day, Year)
11-5-96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George F. SENGSTACK 3929 FERRARA Dr Wheaton MD 20906 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

10-25
1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34826

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Iona Henry McLaughlin

2. Date of Death

November 3, 1996

3. Time of Death

5:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Wilson Health Care Center at Asbury

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

150-28-3240

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 21, 1908

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

403 Russell Avenue, Apt. #E111

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Professor

16b. Kind of Business/Industry

College

17. Father's Name (First, Middle, Last)

Charles Shulenberger

18. Mother's Name (First, Middle, Maiden Surname)

Nettie Varner

19a. Informant's Name/Relationship (Type, Print)

John R. McLaughlin, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

403 Russell Ave., #E111 Gaithersburg, MD 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

11/4/1996

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, attack, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. multi infarction dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D18294

29d. Date signed (Month, Day, Year)

November 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Melnick, M.D., 911 Russell Avenue, Gaithersburg, MD 20879

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

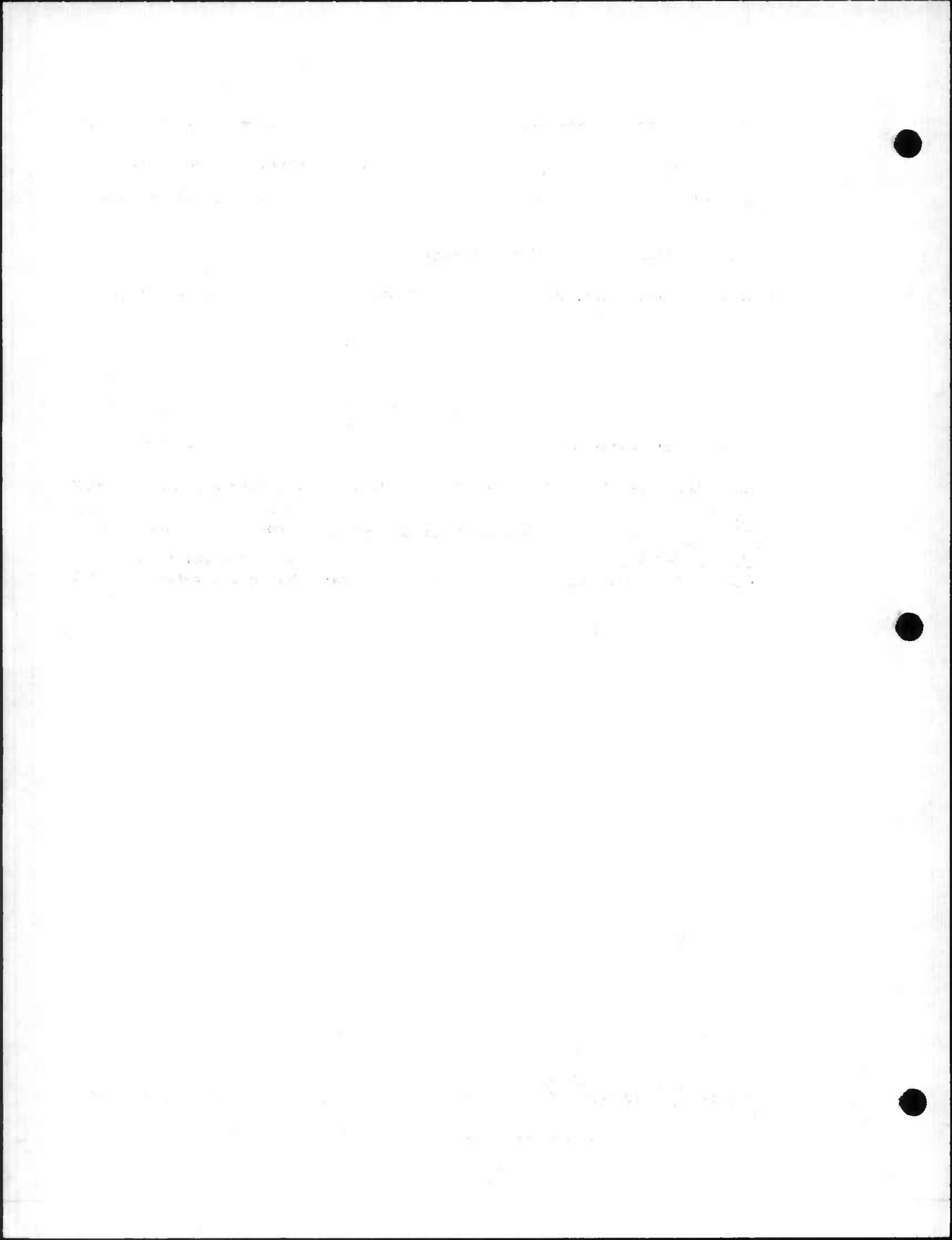
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34827

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE JAMES NELSON

2. Date of Death
Month Day Year

November 3, 1996

3. Time of Death

3:55 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

12 North 4th Street

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

5. Social Security Number

262-68-7861

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 25, 1942

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 North 4th Street

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Caroline County
Public Works

17. Father's Name (First, Middle, Last)

Oliver Nelson

18. Mother's Name (First, Middle, Maiden Surname)

Annie Lee Preston

19a. Informant's Name/Relationship (Type, Print)

Earlene Bell Nelson- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 North 4th Street, Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sandtown Cemetery

Date

11/9/96

20c. Location - City or Town, State

Hillsboro, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home

P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. cardiorespiratory arrest
Due to (or as a consequence of):b. non-small cell lung cancer
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

4m

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D36644

29d. Date signed (Month, Day, Year)

11/5/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN P. MASTROBONA 509 EDENWIL AVE, EASTON, MD, 21601

State
Registrar

31. Date filed (Month, Day, Year)

NOV - 6 1996

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34828

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ISAAC

NOEL

NELSON

2. Date of Death

Month

Day

Year

OCTOBER 26, 1996

3. Time of Death

1830PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3202 AMADOR DRIVE

4b. City, Town, or Location of Death

LANDOVER

4c. County of Death

PRINCE GEORGES

5. Social Security Number

230-14-3987

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JUNE 4, 1924

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND PRINCE GEORGE

10b. County

LANDOVER

10c. City, Town or Location

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3202 AMADOR DRIVE

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

RETIRED CONTROL OFFICER U.S.GOVVERN.

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

LENWOOD NELSON

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE NOEL

19a. Informant's Name/Relationship (Type, Print)

LOUISE A. NELSON/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3202 AMADOR DR., LANDOVER, MD. 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CEDAR HILL CEMETERY 11-2

Date

11-2

20c. Location - City or Town, State

SUITLAND, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

LEWIS FUNERAL HOME

311 N. PATRICK ST., ALEX., VA. 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Hypertensive cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
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available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

OCTOBER 27, 1996

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

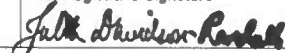
DONALD G. WRIGHT MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34829

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Myron W. Nelson

2. Date of Death

Month Day Year
October 30, 1996

3. Time of Death

1:50 hrs.

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

578-36-6983

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 16, 1928

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

North Carolina

10b. County

Guilford

10c. City, Town or Location

Greensboro

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

910 S. Benbow Road

10f. Zip Code

27406-2110

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Quality Assurance Specialist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

William Nelson

18. Mother's Name (First, Middle, Maiden Surname)

Julia Wilkerson

19a. Informant's Name/Relationship (Type, Print)

Norma M. Nelson Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

910 S. Benbow Road, Greensboro, North Carolina 27406

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Washington Crematory

Date

11/2/96

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave. N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

b. Adult respiratory distress syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous myocardial infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30673

29d. Date signed (Month, Day, Year)

1 NOVEMBER 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Glen Harper, MD Suite 201, 7500 Hanover Parkway, Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34830

| | | | | | | | | | | | | | |
|---|---|---|--|---|---|--|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Thomas DAVID O'Leary</i> | | | | 2. Date of Death
Month <i>October</i> Day <i>31</i> Year <i>1996</i> | | | | 3. Time of Death
<i>1:25 AM</i> | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Southern Maryland Hospital Clinton</i> | | | | 4b. City, Town, or Location of Death
<i>Clinton</i> | | | | 4c. County of Death
<i>Prince George's</i> | | | | |
| Funeral
Director | 5. Social Security Number
<i>578-82-7586</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>78</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>AUG. 2 1918</i> | | 9. Birthplace (State or Foreign Country)
<i>Unknown</i> | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State
<i>Maryland</i> | | 10b. County
<i>Prince George's</i> | | 10c. City, Town or Location
<i>Clinton</i> | | | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
<i>Mariner Health Care of So. Md. 9211 Stewart La Clinton, MD</i> | | | | 10f. Zip Code
<i>20735</i> | | | | 10g. Citizen of What Country?
<i>USA</i> | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12) 11</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Disabled</i> | | | | 16b. Kind of Business/Industry
<i>None</i> | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>James J. O'Leary</i> | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Josephine O'Connell O'Leary</i> | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>John Galzerano (PRD) Social Worker</i> | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>9211 Stewart La. Clinton, MD 20735</i> | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Metropolitan Crematory 11-8-96</i> | | Date
<i>11-8-96</i> | | 20c. Location - City or Town, State
<i>Alexandria, VA</i> | | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | M00173 | | 22. Name and Address of Facility
<i>J.H. Eberwein Mortuary 4433 White Pls La White Pls, MD 20695</i> | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death)
<i>Cardio Pulmonary arrest</i> | | | | | | | | | | | | <i>New onset</i> | |
| Due to (or as a consequence of): | | | | | | | | | | | | <i>2 weeks</i> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | <i>may year</i> | |
| Due to (or as a consequence of): | | | | | | | | | | | | <i>1 year</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Amput @ leg</i>
<i>PEG</i> | | | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>K. Dan...</i> | | | | 29c. License number
<i>D25640</i> | | 29d. Date signed (Month, Day, Year)
<i>Oct. 23, 1996</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Khosrow Davachi, M.D. 1338 Southern Ave. Wash. D.C.</i> | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>NOV 08 1996</i> | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34831

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA WILLIAMS OTT

2. Date of Death

Month Day Year
NOVEMBER 1, 1996

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

5805 42ND AVENUE, APT. #322

4b. City, Town, or Location of Death

HYATTSVILLE

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

577-24-1166

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 14, 1905

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5805 42ND AVENUE, APT. #322

10f. Zip Code

20781

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWNED HOME

17. Father's Name (First, Middle, Last)

JAMES WILLIAMS

18. Mother's Name (First, Middle, Maiden Summa)

JOSEPHINE McFADDEN

19a. Informant's Name/Relationship (Type, Print)

ROBERT BLACK, NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2009 FAIRLAWN STREET, PITTSBURGH, PA 15221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

FORT LINCOLN CEMETERY

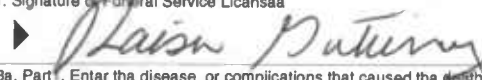
Date

11/5/96

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licansaa



22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME, INC.

3401 BLADENSBURG RD., BRENTWOOD, MD 20722

23a. Part I. Enter the disease, or complications that caused the death

shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

a. SUDDEN DEATH -- CARDIAC DYSRHYTHMIA

Due to (or as a consequence of):

IMMEDIATE

b. PAROXYSMAL ATRIAL FIBRILLATION

Due to (or as a consequence of):

5 YEARS

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, GLUCOSE INTOLERANCE,

EXTENSIVE ARTHRITIS, BILATERAL CATARACTS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner as stated.

29b. Signature and title of certifier



29c. Licansa number

D31001

29d. Date signed (Month, Day, Year)

NOVEMBER 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUART TURKEWITZ, M.D., 7500 GREENWAY CENTER DRIVE, GREENBELT, MD 20770

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature



State

Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with in 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

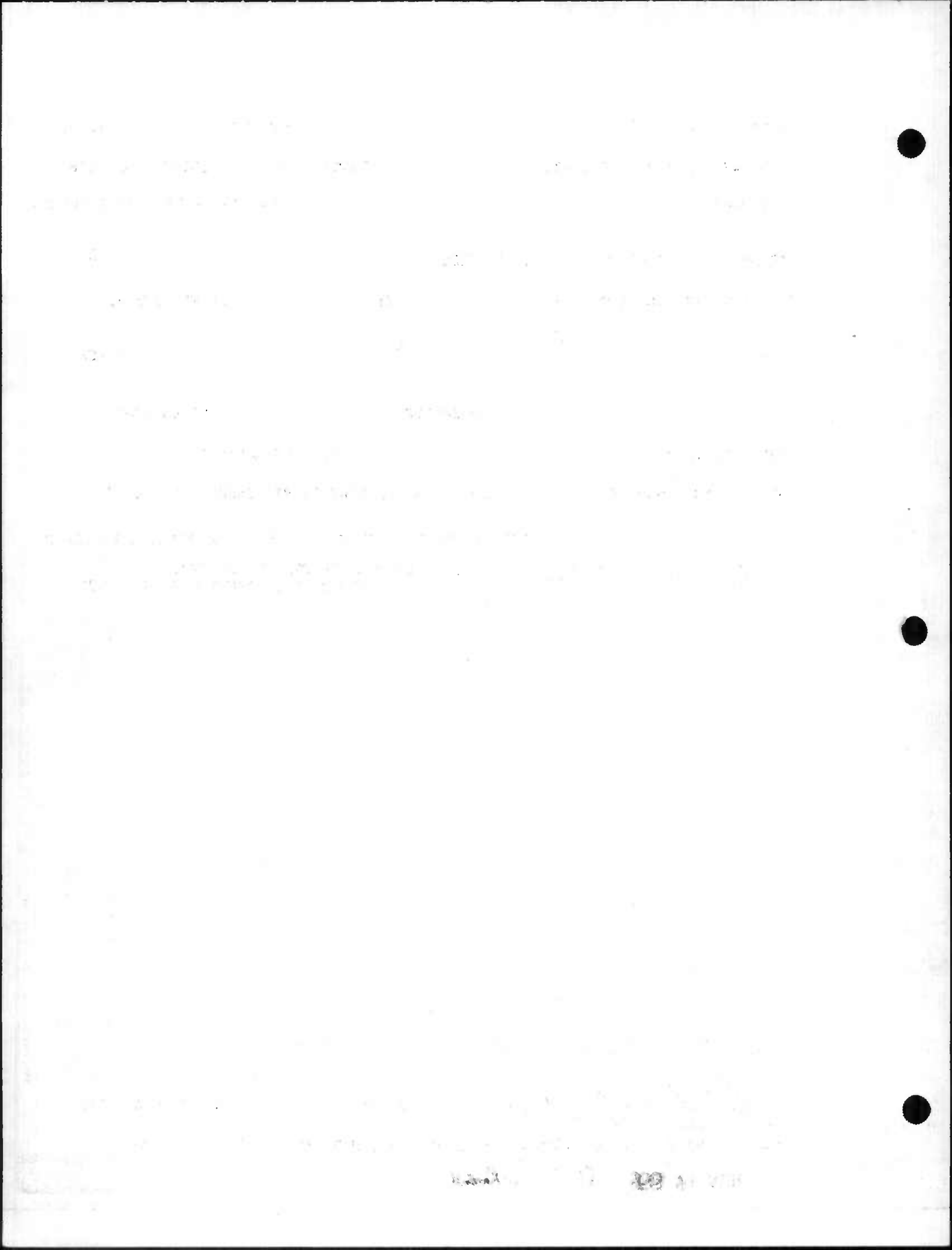
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34832

| | | | | | |
|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEWIS C. OLIVER | | 2. Date of Death
Month: OCTOBER Day: 30 Year: 1996 | | 3. Time of Death
7:25 PM |
| | 4e. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL & MEDICAL CENTER | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY |
| Funeral
Director | 5. Social Security Number
159-12-8152 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months: Days: | If Under 24 Hrs.
Hours: Min. |
| | 8. Date of Birth (Month, Day, Year)
9-14-08 | | 9. Birthplace (State or Foreign Country)
Pa. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Pa. | 10b. County
Bedford | 10c. City, Town or Location
RD #6 Box 334, Bedford, Pa. 15522 | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
RD #6 Box 334 | | 10f. Zip Code
15522 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8 College (1-4 or 5+): | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
heavy equipment operator | | 16b. Kind of Business/Industry
PennDot |
| | 17. Father's Name (First, Middle, Last)
Hosea Oliver | | 18. Mother's Name (First, Middle, Maiden Surname)
Deborah Miller | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Dolly F. Oliver Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RD #6 Box 334, Bedford, Pa. 15522 | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fellowship Cemetery | | 20c. Location - City or Town, State
11-2-96 RD #3 Bedford, Pa. 15522 |
| | 21. Signature of Funeral Service Licensee
Timothy A. Berkebile | | 22. Name and Address of Facility
Bedford, Pa. 15522
Timothy A. Berkebile Funeral Home, Inc. 214 S. Juliana St. | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | e. CONGESTIVE HEART FAILURE
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
1 WEEK |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. ARTERIOSCLEROTIC HEART DISEASE
Due to (or as a consequence of): | | 50 YEARS |
| | | | c. VALVULAR HEART DISEASE
Due to (or as a consequence of): | | 50 YEARS |
| | | | d. | | |
| | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Timothy A. Berkebile | | 29c. License number
D 12779 | | 29d. Date signed (Month, Day, Year)
11/1/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GUY FISCUS M.D., MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD 21502 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 12 1996 | | 32. Registrar's Signature
John Anderson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34833

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie R. Overton

2. Date of Death

November 2, 1996

3. Time of Death

1:35 AM

4a. Facility Name (If not institution, give street and number)

11407 Encore Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

553-30-0888

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 16, 1926

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11407 Encore Drive

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk - Cultural Affairs

16b. Kind of Business/Industry

State Department

17. Father's Name (First, Middle, Last)

Everard Lynne Laundry

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Bayne

19a. Informant's Name/Relationship (Type, Print)

Kathleen Pennewill / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12402 Catoctin View Drive, Mt. Airy, MD 21771

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Crematory

Date

11/4/96

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Ann Zink

22. Name and Address of Facility Hines-Rinaldi Funeral Home

11800 New Hampshire Avenue
Silver Spring, Maryland 2090423a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Adenocarcinoma - Primary site of origin unknown

4 months

Due to (or as a consequence of):

b. Metastatic to bone

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carolyn B Hendricks MD

29c. License number

D37236

29d. Date signed (Month, Day, Year)

November 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN B HENDRICKS MD 9707 MEDICAL CENTER DR ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34834

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anne O'Shaughnessy

2. Date of Death

November 1, 1996

3. Time of Death

6:30 A.M.

4a. Facility Name (If not institution, give street and number)

Manor Care - Fernwood

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

082-03-8933

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 15, 1905

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1316 Fenwick Lane

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

John Stapleton

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hanlon

19a. Informant's Name/Relationship (Type, Print)

Gary O'Shaughnessy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17808 Stoneridge Drive, North Potomac, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Calvary Cemetery

Date

11/4/96

20c. Location - City or Town, State

Woodside, New York

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd.W. Silver Spring, MD 20901

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

1 Week

b. Distended Abdomen

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Recto Sigmoidal Mass

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35791

29d. Date signed (Month, Day, Year)

November 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Merlyn K. Vemury, M.D. 9801 Georgia Avenue, #227, Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34835

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN GRAMMER ORNER

2. Date of Death

November 3 1996

3. Time of Death

1009A

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

211-16-6321

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb. 23, 1925

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1704 Crawford Drive

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Brick Mason

16b. Kind of Business/Industry

Masonry

17. Father's Name (First, Middle, Last)

Harry Orner

18. Mother's Name (First, Middle, Maiden Surname)

Anna Belle Diehl

19a. Informant's Name/Relationship (Type, Print)

Deborah S. Higdon / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1382 Fox Run Court, Frederick, Maryland 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parklawn Memorial Park

Date

Nov. 6, 1996

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta

M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 W. Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Bowel Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Two Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peripheral Embolization

Due to (or as a consequence of):

c. Atrial Fibrillation

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Timothy J. Smith

29c. License number

031839

29d. Date signed (Month, Day, Year)

November 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER C DUNFORD 615 W. MONTGOMERY AVE ROCKVILLE MD 20850-3815

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34836

| | | | | | | | | | | | |
|---|--|--|---|--------------------------------|--|---|--|--|-----------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lucy Josephine Pastorfield | | | | 2. Date of Death
Month Day Year
October 27, 1996 | | | | 3. Time of Death
3:10 PM | | |
| | 4a. Facility Name (If not Institution, give street and number)
William Hill HCC-Cambridge | | | | 4b. City, Town, or Location of Death
CAMBRIDGE | | | | 4c. County of Death
DORCHESTER | | |
| Funeral
Director | 5. Social Security Number
220-16-9742 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
FEB. 2, 1903 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
TALBOT | 10c. City, Town or Location
EASTON | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
814 NORTH WASHINGTON ST. | | | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
6 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BEAUTICIAN | | | | 16b. Kind of Business/Industry
BEAUTY SALON | | | | |
| | 17. Father's Name (First, Middle, Last)
SAMUEL JAMES MARSHALL | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNIE LUBBA | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
BARBARA M. BURKHARDT | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 1, ROYAL OAK, MD 21662 | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SPRING HILL CEMETERY | | Date
11-2-96 | | 20c. Location - City or Town, State
EASTON, MD | | | | |
| | 21. Signature of Funeral Service Licensee
JOHN K. MERCERON CFSP | | | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
200 S. HARRISON ST., EASTON, MD | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 e. <i>Atherosclerotic Cardiovascular disease</i>
 Due to (or as a consequence of):

 b. <i>Hip Fracture</i>
 Due to (or as a consequence of):

 c. _____
 Due to (or as a consequence of):

 d. _____ </td> <td>Approximate Interval Between Onset and Death

20 years

2 wks</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

e. <i>Atherosclerotic Cardiovascular disease</i>
Due to (or as a consequence of):

b. <i>Hip Fracture</i>
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ |
| Immediate Cause (Final disease or condition resulting in death)

e. <i>Atherosclerotic Cardiovascular disease</i>
Due to (or as a consequence of):

b. <i>Hip Fracture</i>
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | Approximate Interval Between Onset and Death

20 years

2 wks | | | | | | | | | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Dementia</i>
<i>History of Colon Cancer</i> | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | |
|---|---|--------------------------|--|-----------------------------------|
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | | | |
|---|---|-------------------------------|---|
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier
<i>[Signature]</i> | 29c. License number
D26388 | 29d. Date signed (Month, Day, Year)
11-01-1996 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Michael Fadden MS 302 Collins, Harlock MD 21643 | | | |
| 31. Date filed (Month, Day, Year)
NOV - 6 1996 | 32. Registrar's Signature
<i>[Signature]</i> | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34837

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Phifer

2. Date of Death

Month
NovDay
3Year
1996

3. Time of Death

6:35 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

246-72-7509

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

01-14-1945

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6615 West Forest Road, #103

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Brady Randolph Faulkner

18. Mother's Name (First, Middle, Maiden Surname)

Beulah Mae Crowder

19a. Informant's Name/Relationship (Type, Print)

Colette Phifer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6615 Forest Rd., #103, Landover, Maryland 20785

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

First Church of God

Cemetery

Date

11/09

1996

20c. Location - City or Town, State

Marshville, N.C.

21. Signature of Funeral Service Licensee

Nancy A. Parcentie

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac Stand Still

Due to (or as a consequence of):

b. metastatic cancer

Due to (or as a consequence of):

c. Internal Bleeding

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. A. ... MD

29c. License number

031265

29d. Date signed (Month, Day, Year)

Nov 5 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

IMAD MUFARRI 16407 - Painter Ridge Dr Bowie MD 20716

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

John ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

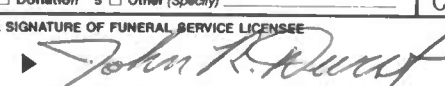

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 34838

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LOYD EMERY PERKINS Jr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOVEMBER 8 1996 | | 3. TIME OF DEATH
4:50 P.M. | |
| 4. SOCIAL SECURITY NUMBER
214-36-6900 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
August 23, 1936 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Williamsport Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Williamsport | |
| 9c. COUNTY OF DEATH
Washington | | | | 10a. STATE
Maryland | | 10b. COUNTY
Washington | |
| 10c. CITY, TOWN OR LOCATION
Williamsport | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
16715 National Pike | |
| 10f. ZIP CODE
21740 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Machinist | | 15b. KIND OF BUSINESS/INDUSTRY
Manufacturing | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Lloyd E. Perkins Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rose Muir | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robin McGowan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 2253, Cumberland, Maryland 21502 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cumberland Crematory 12 Nov 96 | | 20c. LOCATION — City or Town, State
Cumberland, Maryland | | 20d. DATE
12 Nov 96 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Durst Funeral Home 57 Frost Avenue Frostburg, Maryland 21532 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PANCREATIC CANCER
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death 5 mos
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER

TED E. HOWE, MD. | | | | 29c. LICENSE NUMBER
D33700 | | 29d. DATE SIGNED (Month, Day, Year)
NOVEMBER 9, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
TED E. HOWE, MD. 7542 OVERLOOK DRIVE, BOONSBORO, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 12 1996 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34839

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---|---|-------------------------------|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedant's Name (First, Middle, Last)
ANDREW F. PERRY | | | | 2. Date of Death
Month Day Year
November 1, 1996 | | | | 3. Time of Death
6:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
577 14 9526 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
Feb. 13, 1914 | | | | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedant | | | | | | | | | |
| | 10a. State
N/A | | 10b. County
N/A | | 10c. City, Town or Location
Washington, D.C. | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
3120 O Street, S.E. | | | | 10f. Zip Code
20020 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedant Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedant's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
12 | | | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Biological Technician | | | 16b. Kind of Business/Industry
U.S. Government | | |
| | 17. Father's Name (First, Middle, Last)
George F. Perry | | | | 18. Mother's Name (First, Middle, Maiden Sumama)
Rosa Shorter | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Keith A. Perry/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3120 O Street, S.E., Washington, D.C. 20020 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial | | Data
11/8/96 | | 20c. Location - City or Town, State
Suitland, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
McGuire Funeral Service, Inc. 20012
7400 Georgia Avenue, N.W., Washington, D.C. | | | | | |
| | Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
b. ARTERIOSCLEROTIC HEART DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Other: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D01120 | | 29d. Date signed (Month, Day, Year)
NOV 1 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WALTER E. GOETZ MD 2309 SHOREFIELD ROAD WHEATON MD 20902 | | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34840

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Francis Porter, Jr.

2. Date of Death

November 4, 1996

3. Time of Death

5:39 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

9600 Watts Branch Drive

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

014-16-0179

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 18, 1911

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9600 Watts Branch Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

High School Teacher

16b. Kind of Business/Industry

Montgomery County

Public School

17. Father's Name (First, Middle, Last)

Edward Francis Porter, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Sweeney

19e. Informant's Name/Relationship (Type, Print)

Frederick Edward Porter / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12209 Westmont Lane, Bowie, Maryland 20715

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Darnestown Presbyterian Church Cem.

Date

Nov. 7, 1996

20c. Location - City or Town, State

Darnestown.

Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta

M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Inc. 300 West Montgomery Avenue

Rockville, Maryland 20850-2805

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

Minutes

b. Congestive Heart Failure

Due to (or as a consequence of):

Years

c. Diabetes Mellitus

Due to (or as a consequence of):

Years

d. Hyperlipidemia

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Douglas R. Shumaker, M.D.

29c. License number

D27301

29d. Date signed (Month, Day, Year)

November 5, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Douglas R. Shumaker, M.D., 615 W. Montgomery Avenue, Rockville, Maryland 20850-3815

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

J. H. Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34841

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gartfield, W. PARRY

2. Date of Death

Month
November

Day

2

Year

1996

3. Time of Death

1:33 A

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

580-16-6530

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR. 17, 1958

9. Birthplace (State or Foreign Country)

WEST INDIES

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

BURTONSVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3908 BLACKBURN LA. #14

10f. Zip Code

20866

10g. Citizen of What Country?

GREAT BRITIAN

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1980-1983

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALESMAN

16b. Kind of Business/Industry

CAR DEALERSHIP

17. Father's Name (First, Middle, Last)

DAVID M. PARRY

18. Mother's Name (First, Middle, Maiden Surname)

IVA I. SADIO

19a. Informant's Name/Relationship (Type, Print)

IVA I. PARRY/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 SCARLET SAGE CT., BURTONSVILLE, MD. 20866

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

11/8

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers

22. Name and Address of Facility

W. W. CHAMBERS CO., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain Herniation

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Right Hemispheric Stroke

Due to (or as a consequence of):

2 Days

c. Hypertension

Due to (or as a consequence of):

>10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. English MD, Resident Physician

29c. License number

AV 4176435E-8067

29d. Date signed (Month, Day, Year)

November, 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey B English UMMS Green St Baltimore MD 21201

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34842

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William A. Posey

2. Date of Death

Month Day Year
October 29, 1996

3. Time of Death

10:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare-Layhill Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

214-12-7458

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 17, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1708 Tweed Street

10f. Zip Code

20851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Charles H. Posey

18. Mother's Name (First, Middle, Maiden Surname)

Elsie V. Milstead

19a. Informant's Name/Relationship (Type, Print)

Alice Virginia Posey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1708 Tweed Street Rockville, Maryland 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

11/1/96

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

72 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Chronic Renal Failure

Hypertensive Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18924

29d. Date signed (Month, Day, Year)

October 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rafael A. Matheus, M.D. 13018 Georgia Avenue, Wheaton, Maryland 20906

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34843

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TIMOTHY JOHN ROONEY

2. Date of Death

Month Day Year
NOVEMBER 7 1996

3. Time of Death

8:30 AM

4a. Facility Name (If not institution, give street and number)

9503 Prince William Drive

4b. City, Town, or Location of Death

Brandywine

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

219-46-5138

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 12 1946

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brandywine

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9503 Prince William Drive

10f. Zip Code

20613

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Telephone

17. Father's Name (First, Middle, Last)

John A. Rooney

18. Mother's Name (First, Middle, Maiden Surname)

Janice Wheeler Rooney

19a. Informant's Name/Relationship (Type, Print)

Gail M. Rooney (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9503 Prince William Dr Brandywine, MD 20613

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 11-9-96

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

J.H. Eberwein Mortuary

4433 White Pls La White Pls, MD 20695

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. neck cancer
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide ☐ Homicide
☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 38129

29d. Date signed (Month, Day, Year)

November 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vincent C. Chen MD 9131 Piscataway Road Suite 600 Clinton, MD 20735

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34844

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Minnie Viola Beatrice Rill | | | | 2. Date of Death
Month 11 Day 8 Year 96 | | 3. Time of Death
5:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
4752 Rill Road | | | | 4b. City, Town, or Location of Death
Lineboro | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
214-42-1891 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 13, 1913 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Lineboro | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
4752 Rill Road | | 10f. Zip Code
21080 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Farmer | | | | 16b. Kind of Business/Industry
Agriculture | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Levi Sotdorus | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sara Arthur | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Delmos S. Rill / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4700 Rill Road, Lineboro, MD 21080 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethlehem Steltz Cemetery | | 20c. Location - City or Town, State
Glen Rock, PA | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
J.J. Hartenstein Mortuary, Inc.
24 Second St., New Freedom, PA 17349 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
arteriosclerotic
Due to (or as a consequence of):
cardiovascular disease
Due to (or as a consequence of):
years | | | | Approximate Interval Between Onset and Death | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Seizure disorder
Folic acid deficiency | | | | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how Injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Ephraim Benzag | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
D14892 | | | | 29d. Date signed (Month, Day, Year)
11-11-96 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EPHRAIM BENZAG | | | | 31. Date filed (Month, Day, Year)
NOV 1 9 1996 | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
NOV 1 9 1996 | | | | 31. Date filed (Month, Day, Year)
NOV 1 9 1996 | | | |
| | 31. Date filed (Month, Day, Year)
NOV 1 9 1996 | | | | 31. Date filed (Month, Day, Year)
NOV 1 9 1996 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 34845

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARET ROE RUDE | | | | 2. DATE OF DEATH
MONTH 11 DAY 06 YEAR 96 | | 3. TIME OF DEATH
12:15 P M | |
| 4. SOCIAL SECURITY NUMBER
329-16-6431 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 30, 1915 | |
| 8a. FACILITY NAME (If not institution, give street and number)
William Hill Health Care Center | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 8c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Talbot | | 10c. CITY, TOWN OR LOCATION
St. Michaels | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
300 Mill St. | | | | 10f. ZIP CODE
21663 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Levi D. Roe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary O. Shockley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marcia R. Rensen Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2851 Cape Sebastian Cardiff by the Sea, California 92007 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Olivet Cemetery Nov. 11, 1996 | | 20c. LOCATION — City or Town, State
St. Michaels, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Harrison E. Leonard</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Harrison E. Leonard Funeral Home
312 S. Talbot St. St. Michaels, Md. 21663 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
CAD | | | | | | | Approximate Interval Between Onset and Death
years
years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Seizure disorder
hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>M. Niemela</i> | | | | 29c. LICENSE NUMBER
D47311 | | 29d. DATE SIGNED (Month, Day, Year)
11/6/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Suzanne Niemela M.D. 606 Dutchmans Lane Easton, Maryland 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV - 8 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34846

Amended # 7. P.G.C. 11-12-96 CR

Amended # 31. P.G.C. 11-5-96 cr

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Chester E. Reamy

2. Date of Death
Month Day Year
November 3, 19963. Time of Death
7:07am

4a. Facility Name (If not institution, give street and number)

3717 Taylor Street

4b. City, Town, or Location of Death

Brentwood

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

216-22-2482

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)

69 68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

December 27, 1927

9. Birthplace (State or Foreign Country)

Wash. D.C.

Usual Residence of Decedent

10a. State
Maryland10b. County
Prince George's10c. City, Town or Location
Brentwood10d. Inside City Limits
☒ Yes ☐ No

10e. Street and Number

3717 Taylor Street

10f. Zip Code

20722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Firefighter

16b. Kind of Business/Industry

Prince George's County

17. Father's Name (First, Middle, Last)

William McKinley Reamy

18. Mother's Name (First, Middle, Maiden Surname)

Alice Elizabeth Hogan

19a. Informant's Name/Relationship (Type, Print)

Betty L. Reamy-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3717 Taylor Street, Brentwood, Maryland 20722

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

11/7/96

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

Claudette L. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, Md. 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. *Practical myocardial infarction*
Due to (or as a consequence of):b. *Diabetes mellitus*
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Stomach

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D15374

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sotoudek M.D. 7525 Greenway Center Dr., Greenbelt, MD

31. Date filed (Month, Day, Year)

11/11/96

32. Registrar's Signature

*NOV 05 1996 John Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34847

3

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KARLA MARIE ROBERTSON

2. Date of Death

October 29, 1996

3. Time of Death

8:45 AM

4a. Facility Name (If not institution, give street and number)

7914 Carey Branch Drive

4b. City, Town, or Location of Death

Ft. Washington

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

114-76-8584

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

28

8. Date of Birth

FEB 11, 1968

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Ft. Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7914 Carey Branch Drive

10f. Zip Code

20744

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

Collega (1-4or 5+)
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Light Technician

16b. Kind of Business/Industry

Entertainment

17. Father's Name (First, Middle, Last)

Lawrence A. Robertson

18. Mother's Name (First, Middle, Maiden Summa)

DELphine Anderson

19a. Informant's Name/Relationship (Type, Print)

Delphine Anderson (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7914 Carey Branch Drive, Ft. Washington, Md 20744

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

11/1/96

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Alex S. Pope Jr. M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES
5538 Marlboro Pike, Forestville, Md 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Primary Pulmonary Hypertension

Approximate Interval Between Onset and Death

One year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joel Sewchand

29c. License number

D29646

29d. Date signed (Month, Day, Year)

10-31-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOEL SEWCHAND M.D. POBOX 975 LA PLATA - MD. 20646

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

John Anderson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 34848

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Annie L. Peterson | | 2. DATE OF DEATH
MONTH DAY YEAR
October 30 1996 | | 3. TIME OF DEATH
6:00 A M | |
| 4. SOCIAL SECURITY NUMBER
246-30-2636 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
71 YRS. | |
| 9a. FACILITY NAME (If not institution, give street and number)
MANOR CARE NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
LARGO | | 9c. COUNTY OF DEATH
PRINCE GEORGE'S | |
| 10a. STATE
N/A | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
WASHINGTON, DC | |
| 10d. INSIDE CITY LIMITS?
XX YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
5040 SHERIFF RD. NE | | 10f. ZIP CODE
20019 | |
| 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9th
College (1-4 or 5+) HOUSEKEEPER | |
| 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOUSEKEEPER | | 16b. KIND OF BUSINESS/INDUSTRY
PVT. | | 17. FATHER'S NAME (First, Middle, Last)
GUS WELLS | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
BESSIE JENKINS | | 19a. INFORMANT'S NAME (Type/Print)
CURFIELD PETERSON/ HUSBAND | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5040 SHERIFF RD. NE WASH., DC 20019 | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
FT. LINCOLN CEMETERY | | 20c. LOCATION — City or Town, State
BRENTWOOD, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Maura J. Braxton | | 22. NAME AND ADDRESS OF FACILITY
MARSHALL'S FUNERAL HOME
4308 SUITLAND RD. SUITLAND, MD 20746 | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Cancer of the Esophagus 2 months
DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Sam Tellawi | | 29c. LICENSE NUMBER
034274 | | 29d. DATE SIGNED (Month, Day, Year)
10.30.96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR Sam Tellawi 7701 Old Branch Ave suite 102 Clinton, MD 20735 | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 06 1996 | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34849

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SAMUEL MELVIN ROYSTER

2. Date of Death

Month
11Day
06Year
1996

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

804 Booker Place

4b. City, Town, or Location of Death

Seat Pleasant

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

228-22-4702

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12 03 1926

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

804 Booker Place

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

9/4/45 to 1/24/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Addison Royster

18. Mother's Name (First, Middle, Maiden Surname)

Julia Ann Yancey

19a. Informant's Name/Relationship (Type, Print)

Palmer L. Royster/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

804 Booker Place, Seat Pleasant, Maryland 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

11/09
1996

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perconti

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

LUNG CANCER

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Phys Arunas

29c. License number

20459

29d. Date signed (Month, Day, Year)

11-8-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

50 IRVING ST NW WASHINGTON DC 20422

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34850

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANDREW REININGER

2. Date of Death

Month Day Year
OCTOBER 31 1996

3. Time of Death

2:10 AM

4a. Facility Name (If not Institution, give street and number)

LARKIN CHASE NURSING HOME

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

350 07 3564

6. Sex

M 20 F

7. Age (in yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 6, 1907

9. Birthplace (State or Foreign Country)

Hungary

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

Yes 20 No

10e. Street and Number

13453 Yorktown Drive

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Elevator Operator

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Andrew Reininger

18. Mother's Name (First, Middle, Maiden Surname)

Eva Valentine

19a. Informant's Name/Relationship (Type, Print)

Andrew A. Reininger Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13453 Yorktown Drive Bowie Maryland 20715

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

10/31/96

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PROSTATE CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation
20 Accident 60 Could not be determined
30 Suicide
40 Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert E. Evans MD

29c. License number

D 50343

29d. Date signed (Month, Day, Year)

10 - 31 - 96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KELVIN HAO, MD 3231 SUPERIOR LANE A-G, BOWIE, MARYLAND 20715

31. Date filed (Month, Day, Year)

NOV 05 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34851

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Ann Ray

2. Date of Death

Month Day Year
October 31, 1996

3. Time of Death

7:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1401 Golden Rod Ct. Apt. E

4b. City, Town, or Location of Death

Belcamp

4c. County of Death

Harford

5. Social Security Number

213-38-7977

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

8. Date of Birth

Month Day Year
July 22, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Belcamp

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1401 Golden Rod Ct. Apt. E

10f. Zip Code

21017

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Property Manager

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

James C. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Choate

19a. Informant's Name/Relationship (Type, Print)

Mr. Richard R. Smith (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

445 Quaker Bottom Rd., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris, & Co., Inc.

Date

11/4/96

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Kirsten Amy Unglesbee

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Artery Disease

Due to (or as a consequence of):

ASCVD

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

NA

28b. Time of Injury

NA

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NA

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. S. Prabhu

DME

29c. License number

OCME

29d. Date signed (Month, Day, Year)

11-01-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G.S. Prabhu 1810 Belair Rd #102 Fallston MD, 21047. 410-879-6564.

31. Date filed (Month, Day, Year)

NOV 4 1996

32. Registrar's Signature

J. S. Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

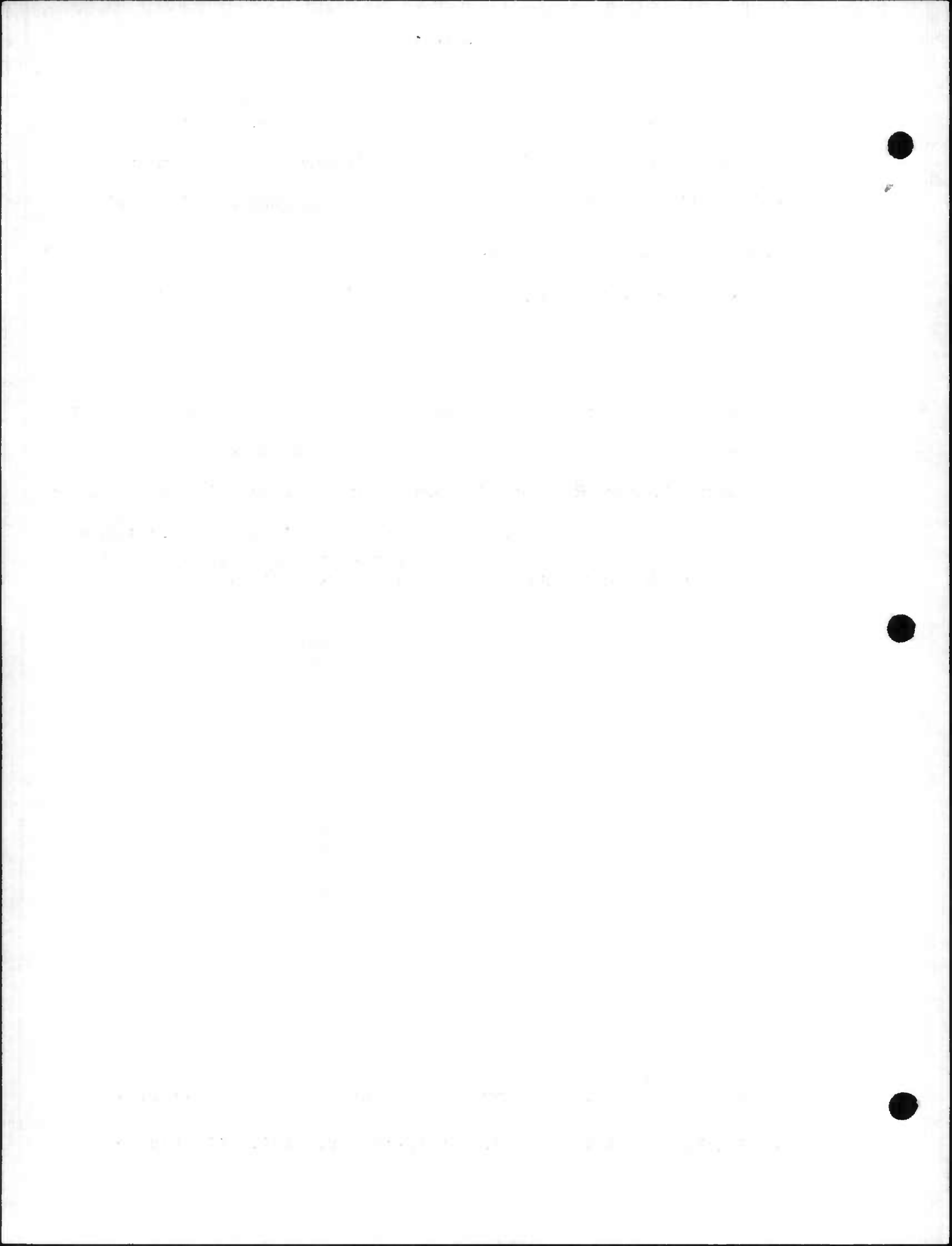
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34852

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Ann Redd

2. Date of Death

Month

Day

Year

Nov

3

96

3. Time of Death

1:39P

4a. Facility Name (If not Institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

303-34-9475

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
December 17, 1931

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

213 South Sixth Street

10f. Zip Code

21629

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Caucasian

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Roy Joseph Redd

18. Mother's Name (First, Middle, Maiden Surname)

Edith Lomeda Mardis

19a. Informant's Name/Relationship (Type, Print)

Edith Poole Legg daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1902 Cecil Court, Chester, Maryland 21619

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Capitol Crematory


Date

11/5

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Moore Funeral Home, P.A.

PO Drawer B, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

039749

29d. Date signed (Month, Day, Year)

11/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Gregg Oliver, M.D., 503 Dutchmen's Lane, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

NOV 11 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34853

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ray Clayford Resh

2. Date of Death

November 3, 1996

3. Time of Death

3:09 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Allegany County Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

213-18-2859

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 23, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

23 E. Roberts Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7 th

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Allegany Co. Board of
Education

17. Father's Name (First, Middle, Last)

Earl Resh

18. Mother's Name (First, Middle, Maiden Surname)

Oma Platter

19a. Informant's Name/Relationship (Type, Print)

Marie M. Resh/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23 E. Roberts St., Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Grantsville Cem. Nov 7, 1996

Date

20c. Location - City or Town, State

Grantsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A., P.O. Box 275
179 Miller St., Grantsville, MD 2153623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Endstage Parkinson's Syndrome with Severe Dysphagia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D19750

29d. Date signed (Month, Day, Year)

Nov. 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V.A. Ranjithan, M.D., 517 Oldtown Rd., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 12 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34854

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DOUGLAS GORDON RYAN SR. | | | | 2. Date of Death
Month Day Year
NOVEMBER 2, 1996 | | 3. Time of Death
1545 PM | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
216-28-0361 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN 21 1930 | |
| | 9. Birthplace (State or Foreign Country)
PA. | | 10a. State
W. VA. | | 10b. County
MINERAL | | 10c. City, Town or Location
WILEY FORD | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
P.O. BOX# 72 | | 10f. Zip Code
26767 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
G&G MANUFACTURING CO. | | 16b. Kind of Business/Industry
DRAPERY MANUF. | | | |
| | 17. Father's Name (First, Middle, Last)
DANIEL I. RYAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MAUDE CLITES | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JESSIE RYAN WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX# 72 WILEY FORD W. VA. 26767 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CUMBERLAND CREMATORY NOV | | 20c. Date
3 1996 | | 20d. Location - City or Town, State
CUMBERLAND MARYLAND | |
| | 21. Signature of Funeral Service Licensee
<i>Dale L. Merritt</i> | | | | 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME
404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular fibrillation minutes
Due to (or as a consequence of):
b. Myocardial infarction minutes
Due to (or as a consequence of):
c. Coronary artery disease years
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Gallstones & Jaundice
Renal failure, chronic
Coronary artery disease | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
<i>R. Espina, MD</i> | | 29c. License number
D03459 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 3, 1996 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. ESPINA, MD 902 Seton Drive, Cumberland, Md 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | 32. Registrar's Signature
<i>Johanna Davidson Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34855

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary E. Reinecker

2. Date of Death
Month Day Year
October 31, 19963. Time of Death
6:30 AM

4a. Facility Name (If not institution, give street and number)

5006 Euclid Drive

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-28-5848

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 22, 1922

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5006 Euclid Drive

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Paul Raeburn

18. Mother's Name (First, Middle, Maiden Surname)

Laura Smith

19a. Informant's Name/Relationship (Type, Print)

H. Keith Reinecker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5006 Euclid Drive Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

11/4/96 Silver Spring, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Alzheimer's disease

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D000957

29d. Date signed (Month, Day, Year)

10-31-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donald L Bucy 809 Veirs Mill Rd Rockville Md 20851

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
MARIO Hernandez | | 2. Date of Death
Month OCTOBER Day 29 Year 1996 | | 3. Time of Death
12:57 P.M. | |
| 4a. Facility Name (If not institution, give street and number)
8391 WASHINGTON BLVD | | 4b. City, Town, or Location of Death
Jessup | | 4c. County of Death
HOWARD COUNTY | |
| 5. Social Security Number
none | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
44 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
October 17, 1952 | | 9. Birthplace (State or Foreign Country)
Mexico | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
802 North Hampton Dr. | | 10f. Zip Code
20903 | |
| 10g. Citizen of What Country?
Mexico | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Mexican | | 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
Various Firms | | 17. Father's Name (First, Middle, Last)
Pedro Hernandez | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Maria Dorotea Ramirez | | 19a. Informant's Name/Relationship (Type, Print)
Sabina Aguilera / Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
802 North Hampton Dr. Silver Spring, MD 20903 | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hidalgo Cemetery | | 20c. Location - City or Town, State
Nov. 9, 1996 Mexico El Bondho, Hidalgo, | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Takoma Funeral Home, Inc.
254 Carroll St. NW Washington, DC 20012 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.
Multiple Injuries | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) PARKING LOT | | 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year)
10-29-96 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred
Crushed between Two Trucks | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Parking Lot | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
8391 Washington Blvd | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Donald G. Wright MD | | 29c. License number
O.C.M.E. | |
| 29d. Date signed (Month, Day, Year)
OCTOBER 30, 1996 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DONALD G. WRIGHT MD
111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
NOV 04 1996 | |
| 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34857

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nathaniel Rogers

2. Date of Death

Month Day Year
October 31, 1996

3. Time of Death

10:30 pm

4a. Facility Name (If not institution, give street and number)

3612 Saul Road

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

289-16-6153

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 4, 1904

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3612 Saul Road

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1925
195113. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Investigator

16b. Kind of Business/Industry

Private
Detective Agency

17. Father's Name (First, Middle, Last)

Henry Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Katherine / Not Available

19a. Informant's Name/Relationship (Type, Print)

Dorothy B. Rogers / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3612 Saul Road Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)November 13, 1996
Arlington National Cemetery

Date

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-350123a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. End Stage Parkinson's Disease

Due to (or as a consequence of):

b. Anorexia Malnutrition

Due to (or as a consequence of):

c. Immobility Weakness

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

0101052849

29d. Date signed (Month, Day, Year)

November 1, 1996

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Ana Blackmon M.D. National Naval Medical Center Bethesda, Maryland

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 04 1996

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34858

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES THOMAS RANKIN | | | | 2. Date of Death
Month Day Year
OCT 28 1996 | | 3. Time of Death
1445 (PM) | |
| | 4a. Facility Name (If not institution, give street and number)
LAUREL REGIONAL HOSPITAL | | | | 4b. City, Town, or Location of Death
LAUREL, MARYLAND | | 4c. County of Death
PG COUNTY | |
| Funeral
Director | 5. Social Security Number
179-46-9124 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
40 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT. 14, 1956 | |
| | 9. Birthplace (State or Foreign Country)
PA. | | 10a. State
VA. | | 10b. County
NONE | | 10c. City, Town or Location
VIRGINIA BEACH | |
| To Be Completed by Funeral Director | 10d. Instate City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3004 GLASTONBURY DR. | | 10f. Zip Code
23456 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1976-1996 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
U.S. NAVY | | 16b. Kind of Business/Industry
DEFENSE | | | |
| | 17. Father's Name (First, Middle, Last)
JAMES THOMAS RANKIN SR. | | 18. Mother's Name (First, Middle, Maiden Surname)
MAUREEN ONIELL | | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
GWYNN H. RANKIN/WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAME AS ITEM #10 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON NATIONAL CEMETERY | | 20c. Location - City or Town, State
11/7 ARLINGTON, VA. | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
W.W. Chambers | | 22. Name and Address of Facility
W. W. CHAMBERS CO., RIVERDALE, MD. 20737 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Causa (Final disease or condition resulting in death)

a. ACUTE-MYOCARDIAL INFARCTION (HEART ATTACK)
Due to (or as a consequence of):
b. ARTERIOSCLEROSIS OF THE CORONARY ARTERY
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
d.

Sequitely list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
0-IMMED.
UNK.
UNK. | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
NOV 04 1996 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
T. T. CATCHINGS, CAPT, MC, USN | | 29c. License number
#030030 (GA) | | 29d. Date signed (Month, Day, Year)
30 OCT 1996 | |
| | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20889 | | 31. Date filed (Month, Day, Year)
NOV 04 1996 | | 32. Registrar's Signature
J. Davidson-Randall | | | |

ITEM: 5. PER FH. FILM g-741
11/20/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34859

Reg. No.

| | | | | | | | | |
|-------------------------------------|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thomas Leo Spaight | | | | 2. Date of Death
Month Day Year
October 29, 1996 | | 3. Time of Death
7:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Montgomery General Hospital | | | | 4b. City, Town, or Location of Death
Olney | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
577-28-1545
570-40-8839 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 14, 1905 | |
| | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| To Be Completed by Funeral Director | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chief of Information Services U.S. Government | |
| | 16b. Kind of Business/Industry | | | | 17. Father's Name (First, Middle, Last)
John David Spaight | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Williams | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lorraine Deskevich | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15021 Red Clover Drive Rockville, Maryland 20853 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | 20c. Location - City or Town, State
11/2/96 Silver Spring, Maryland | | 21. Signature of Funeral Service Licensee
 | |
| | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W. Silver Spring, Md 20901 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cardiac Failure
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Barry Boden, M.D. | |
| | 29c. License number
D 50899 | | 29d. Date signed (Month, Day, Year)
October 30, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barry Boden, M.D. 2102 Medical Park Drive, Suite 305, Silver Spring, MD 20902 | | 31. Date filed (Month, Day, Year)
NOV 04 1996 | |
| 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

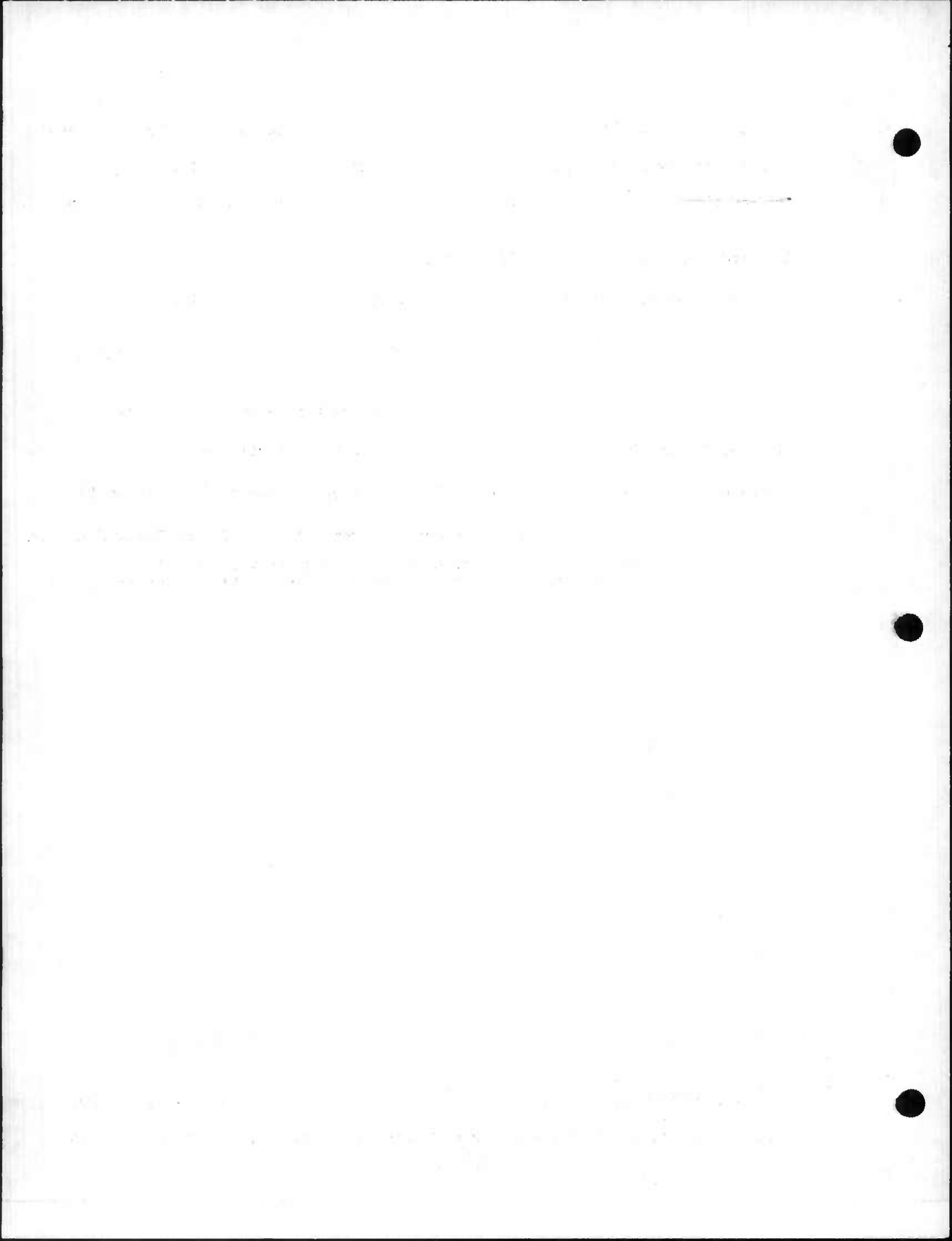
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Referred to Dr. John Tauber, ME 10-30-96

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



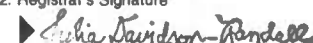
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34860

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARGUERITE C. SULLIVAN | | | | 2. Date of Death
Month NOVEMBER Day 1 Year 1996 | | 3. Time of Death
12:15PM | |
| | 4a. Facility Name (If not institution, give street and number)
6263 LANDING NECK ROAD | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
TALBOT | |
| Funeral
Director | 5. Social Security Number
214-18-4397 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth
Month, Day, Year
OCT. 20, 1922 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
MARYLAND | | 10b. County
TALBOT | | 10c. City, Town or Location
EASTON | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
6263 LANDING NECK ROAD | | | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last)
FRANK CAPP | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNA PEARL GANNON | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DANA L. SULLIVAN/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5957 ROUTE 14, EAST NEW MARKET, MD 21631 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WHITEMARSH CEMETERY | | Date
11/5 | | 20c. Location - City or Town, State
TRAPPE, MARYLAND | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
200 S. HARRISON ST., EASTON, MD 21601 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. OVARIAN CANCER
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
3 mo | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
201225 | | 29d. Date signed (Month, Day, Year)
11-4-96 | |
| | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
STEPHEN P. CARNEY, M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV - 6 1996 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

96 34861

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Hortense Smith</i> | | | | 2. DATE OF DEATH
MONTH <i>11</i> DAY <i>03</i> YEAR <i>96</i> | | 3. TIME OF DEATH
<i>10:15 A</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>577-10-1128</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>90</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>12-20-06</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Washington, DC</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>PineView Nsg & Rehab Center - 9106 Pineview Lane</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Clinton</i> | |
| 9c. COUNTY OF DEATH
<i>PG</i> | | | | 10a. STATE
<i>MD.</i> | | 10b. COUNTY
<i>Prince Georges</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Clinton</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>9106 Pineview Lane</i> | |
| 10f. ZIP CODE
<i>20735</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+) <i></i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>N/A</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Dennis S. Brown</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Ida M. Crampton</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Ella L. Jones</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>6802- Surratts Rd., Clinton, Md. 20735</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Harmony Memorial Park</i> | | 20c. LOCATION — City or Town, State
<i>11/7 Landover, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Melita W. Hackett</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Hackett's Funeral Chapel, Inc.
814- Upshur Street, N.W.</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Acute Myocardial infarction</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death
<i>2h.</i> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. <i>Coronary Artery disease Hypertension</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | <i>72h</i> | |
| | | c. <i>organic Brain Syndrome</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | <i>72m</i> | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Laxmi Berwa, M.D.</i> | | | | 29c. LICENSE NUMBER
<i>D-24535</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>11.4.96</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Dr. Laxmi Berwa, M.D. 7700 Old Branch Ave., Clinton, Md. 20735</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>NOV 05 1996</i> | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34862

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Snowden

2. Date of Death

November 1, 1996

3. Time of Death

12:50 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Hyattsville Manor

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

5. Social Security Number

577-36-2274

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 24, 1910

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

827 Ray Road

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cafeteria Helper

16b. Kind of Business/Industry

State of MD cafeteria

17. Father's Name (First, Middle, Last)

Herbert Gifford

18. Mother's Name (First, Middle, Maiden Surname)

Mary Roberts

19a. Informant's Name/Relationship (Type, Print)

Ira Mae Gifford

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

827 Ray Rd. Hyattsville, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD National Mem Park

Date

11-6

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Wash., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Breast Cancer

Approximate Interval Between Onset and Death

2 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tom P. Kannarskat

29c. License number

D-20062

29d. Date signed (Month, Day, Year)

Nov 1st, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Tom P. Kannarskat, 8201 16th St, Silver Spring, Maryland 20910

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34863

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LARRY DONALL STRICKLAND

2. Date of Death

Month Day Year
NOV 2 1996

3. Time of Death

9:13 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

425-92-2185

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 2, 1949

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11706 Mordente Street

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Dec. 199213. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Military Enlisted/Retired

16b. Kind of Business/Industry

United States Navy

17. Father's Name (First, Middle, Last)

Bill

Strickland

18. Mother's Name (First, Middle, Maiden Surname)

Daisy

Lee

Williams

19a. Informant's Name/Relationship (Type, Print) (wife)

Vernestine Sanders Strickland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11706 Mordente Street, Clinton, Maryland 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cemetery

Date

Nov. 8, 1996

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Bennie L. Mason

22. Name and Address of Facility

Latney's Funeral Home, Inc.
3831 Georgia Avenue, N.W.; Washington, D.C. 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Septic Shock

2 days

Due to (or as a consequence of):

b.

Acute Enterocolitis of Unknown Etiology

6 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wesley B. Mason M.D.

29c. License number

D 22235

29d. Date signed (Month, Day, Year)

11/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wesley B. Mason M.D., 10810 Connecticut Ave, Kensington, Md.
20895

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34864

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Rawlings Shope

2. Date of Death

November 5, 1996

3. Time of Death

6:00 pm

4a. Facility Name (If not institution, give street and number)

16608 Briardale Road

4b. City, Town, or Location of Death

Derwood

4c. County of Death

Montgomery

5. Social Security Number

218-38-9841

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb. 23, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3311 Madison Street

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Associate

16b. Kind of Business/Industry

Hecht Company

17. Father's Name (First, Middle, Last)

Lyman Rawlings

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jane Davis

19a. Informant's Name/Relationship (Type, Print)

Howard R. Shope - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7617 Wheat Fall Court, Rockville, Maryland 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery 11/12/96 Arlington, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Coni Lynn Hesch - Brady

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip G. Henjum, M.D.

29c. License number

D35045

29d. Date signed (Month, Day, Year)

November 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip G. Henjum, M.D. 3416 Olandwood Court #200, Olney, Maryland 20832

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

John D. Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34865

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Mae Scopin

2. Date of Death

November 5, 1996

3. Time of Death

12:30pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-54-5166

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 3, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5125 70th Place

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James William Ward, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Virginia Sampson

19a. Informant's Name/Relationship (Type, Print)

Carl E. Scopin, Sr. - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5125 70th Place, Hyattsville, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

11/8/96

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

Henry J. Land

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, Md. 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

years

Due to (or as a consequence of):

b. Coronary Artery Disease

years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Surinder Singh

29c. License number

D28920

29d. Date signed (Month, Day, Year)

11/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surinder Singh, 7319A Hanover Parkway, Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

Julia A. Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

3. The third part of the document is a list of names and addresses.

4. The fourth part of the document is a list of names and addresses.

5. The fifth part of the document is a list of names and addresses.

6. The sixth part of the document is a list of names and addresses.

7. The seventh part of the document is a list of names and addresses.

8. The eighth part of the document is a list of names and addresses.

9. The ninth part of the document is a list of names and addresses.

10. The tenth part of the document is a list of names and addresses.

11. The eleventh part of the document is a list of names and addresses.

12. The twelfth part of the document is a list of names and addresses.

13. The thirteenth part of the document is a list of names and addresses.

14. The fourteenth part of the document is a list of names and addresses.

15. The fifteenth part of the document is a list of names and addresses.

16. The sixteenth part of the document is a list of names and addresses.

17. The seventeenth part of the document is a list of names and addresses.

18. The eighteenth part of the document is a list of names and addresses.

19. The nineteenth part of the document is a list of names and addresses.

20. The twentieth part of the document is a list of names and addresses.

21. The twenty-first part of the document is a list of names and addresses.

22. The twenty-second part of the document is a list of names and addresses.

23. The twenty-third part of the document is a list of names and addresses.

24. The twenty-fourth part of the document is a list of names and addresses.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34866

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Helen A. Smith | | | | 2. Date of Death
Month Day Year
October 31, 1996 | | 3. Time of Death
6:40 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Fort Washington Hospital | | | | 4b. City, Town, or Location of Death
Ft. Washington | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
578-84-7199 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 | 8. Date of Birth (Month, Day, Year)
Oct. 5, 1921 | 9. Birthplace (State or Foreign Country)
Washington, DC | | | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
Maryland | 10b. County
Prince George's | 10c. City, Town or Location
Oxon Hill | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10a. Street and Number
826 Shelby Drive | | | 10f. Zip Code
20745 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | |
| | 17. Father's Name (First, Middle, Last)
Julian Vincent Lynn | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Ann Murphy | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Benny A. Smith/ husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
826 Shelby Drive Oxon Hill, Md. 20745 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | 20c. Location - City or Town, State
Suitland, Maryland | | 20d. Date
11-4-96 | |
| | 21. Signature of Funeral Service Licensee
<i>Matthew H. H.</i> | | | | 22. Name and Address of Facility
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <u>Respiratory Insufficiency</u>
Due to (or as a consequence of):
b. <u>Chronic Obstructive Pulmonary Disease</u>
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>BM Medford</i> | | | | 29c. License number
D07348 | | 29d. Date signed (Month, Day, Year)
NOV-1-1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R.M. NEDZBALA, JR 11701 LIVINGSTON RD., FORT WASHINGTON MD 20744 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | | | 32. Registrar's Signature
<i>John A. Anderson</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34867

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

FRED JAMES STEVENS SR.

2. Date of Death

Month

Day

Year

10

31

96

3. Time of Death

1:42 PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

152-18-3568

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

9-19-28

9. Birthplace (State or Foreign Country)

N.J.

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ASHTON

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

17947 ASHTON CLUB WAY

10f. Zip Code

20861

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married☒ Married☐ Widowed☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

AFRO-AMERICAN

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

RUBEN STEVENS SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARIE WRIGHT

19a. Informant's Name/Relationship (Type, Print)

ANNETTE STEVENS (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17947 ASHTON CLUB WAY, ASHTON, MD 20861

20a. Method of Disposition

☒ Burial☐ Cremation☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND NATIONAL

Date

11/6/96

20c. Location - City or Town, State

LAUREL, MD.

21. Signature of Funeral Service Licensee

James E. Williams

22. Name and Address of Facility

THE HOUSE OF WILLIAMS FUNERAL SERVICE
411 KENNEDY STREET N.W. WASH. D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Amythra - Ventricular Fibrillation

Due to (or as a consequence of):

b. Anterior Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James E. Williams, M.D.

29c. License number

K08381

29d. Date signed (Month, Day, Year)

October 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara A. Williams, M.D. 1811 Prince Philip Dr, Oak Md. 20832

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

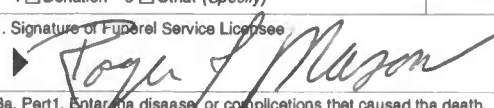
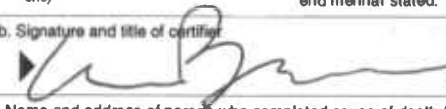
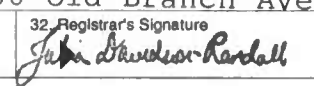
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34868

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard V. Speed | | | | 2. Date of Death
Month Day Year
Nov 3, 1996 | | | | 3. Time of Death
10:40am | |
| | 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death
Clinton | | | | 4c. County of Death
P.G. | |
| Funeral
Director | 5. Social Security Number
231-44-3381 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
55 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb 10, 1941 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Charles | | 10c. City, Town or Location
Waldorf | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
128 Jefferson Road | | | | 10f. Zip Code
20602 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Receiving Clerk | | | | 16b. Kind of Business/Industry
Bread Co. | | | |
| | 17. Father's Name (First, Middle, Last)
Melvin R. Speed | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Mary Nickens | | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Rodney Speed | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
128 Jefferson Road Waldorf Md 20602 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Grove Cemetery | | 20c. Location - City or Town, State
Nov 7, 1996 Stafford Va | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bailey Funeral Home
1201 White St Frederickburg Va | | | | | |
| | 23a. Pert I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Intracerebral Hemorrhage
Hypertension | | | | | | Approximate Interval Between Onset and Death
48hrs
1yr | | | |
| | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
{ | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
no
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
no
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 MD Attending | | 29c. License number
24535 | | 29d. Date signed (Month, Day, Year)
Nov 4, 1996 | | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Dr. Berwa 7700 Old Branch Ave Clinton Md 20735 | | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34869

Certificate of Death

Reg. No.

Amended 20a, 20b, & 20c. P.G.C. 10/6/96cr

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM HENRY SMITH

2. Date of Death

Month

Day

Year

10

31

96

3. Time of Death

4:30 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

367-34-2330

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

02

09

36

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

137 Joyceton Way

10f. Zip Code

20774

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Program Analyst

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Henry Clay Smith

18. Mother's Name (First, Middle, Maiden Surname)

Leona Shepherd

19a. Informant's Name/Relationship (Type, Print)

Frances Smith/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

137 Joyceton Way, Upper Marlboro, MD 20774

20a. Method of Disposition

☒ Burial ☐ Cremation ☒ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Woodlawn Cemetery
Maryland Veterans Cemetery

Date

11/9/96

20c. Location - City or Town, State

Chester, Michigan
Cheltenham Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentie

22. Name and Address of Facility

J. B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 2078523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Intracerebral Hemorrhage

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Hypertension

Due to (or as a consequence of):

years

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital: ☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicidal ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

James Catavenis, M.D.

29c. License number

D30318

29d. Date signed (Month, Day, Year)

11/1/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Catavenis, M.D. 4001 Hospital Center Drive, Cheverly, MD

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John A. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34870

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sinaida Sidelinger

2. Date of Death
Month

November

Day

5

Year

1996

3. Time of Death

6:30AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-60-6870

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth
(Month, Day, Year)

March 10, 1922

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Brentwood

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3708 Taylor Street

10f. Zip Code

20722

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Victoria Anan, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3708 Taylor Street Brentwood Maryland 20722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

11/7/96

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fort Lincoln Funeral Home, Inc.

3401 Bladensburg Rd, Brentwood Md 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Arrest and Hypoxia

Approximate
Interval Between
Onset and Death

Minutes

Due to (or as a consequence of):

b. Pneumonia and Aspiration

Hours

Due to (or as a consequence of):

c. Dementia and CVA

Years

Due to (or as a consequence of):

d. Atherosclerotic Vascular Disease

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33483

29d. Date signed (Month, Day, Year)

November 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pradeep Srivastava, MD 7227-B Hanover Parkway, Greenbelt Md 20770

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34871

Certificate of Death

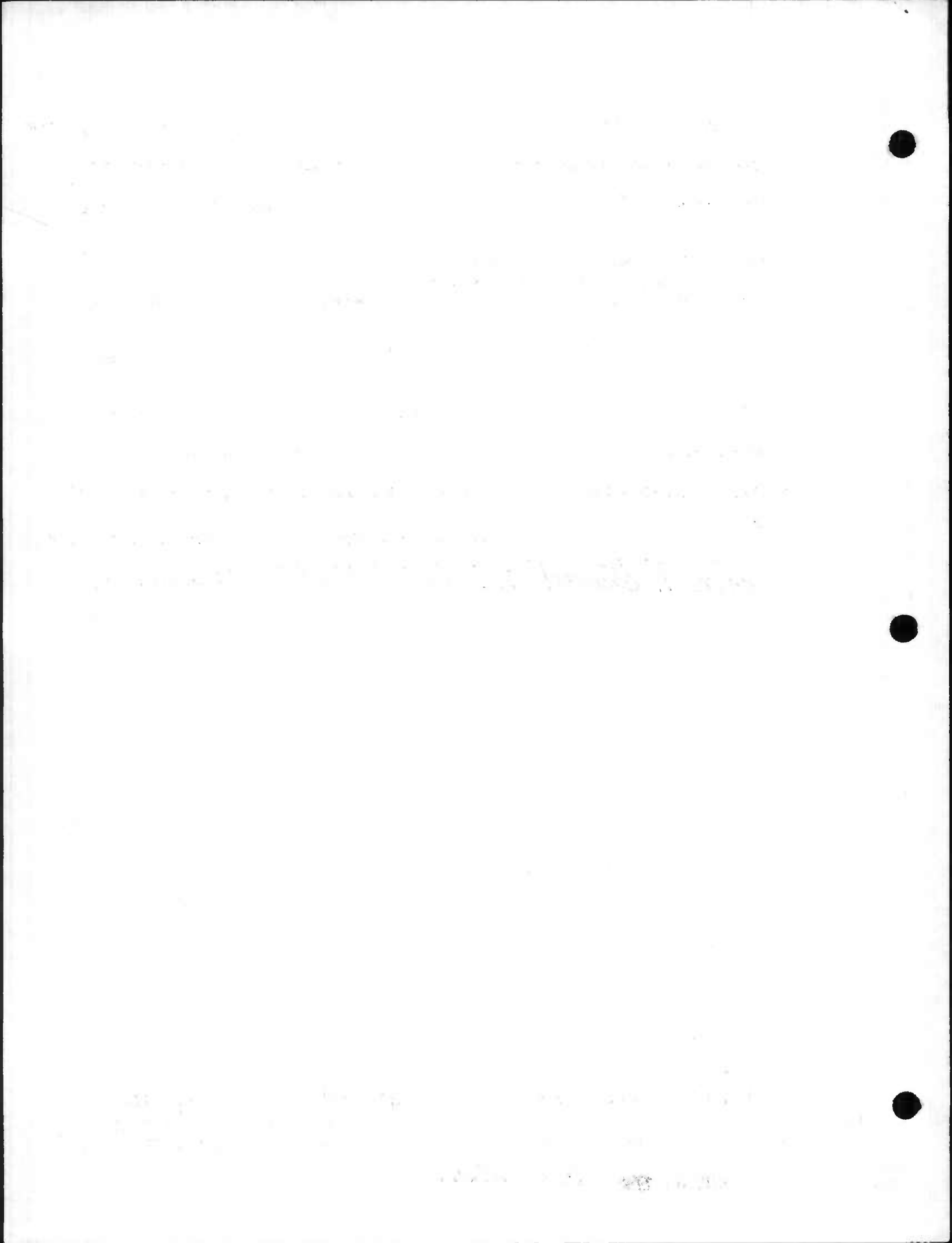
Reg. No.

| | | | | | | | | | | | |
|---|---|--|---|---|--|---------------------------------|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LUCIUS D. SMITH | | | | 2. Date of Death
Month Nov Day 2 Year 1996 | | | | 3. Time of Death
7:37 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
RANDOLPH HILLS NURSING HOME | | | | 4b. City, Town, or Location of Death
Wheaton | | | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
579-07-2786 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 25, 1917 | | 9. Birthplace (State or Foreign Country)
Georgia | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Wheaton | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
4011 Randolph Road | | | | 10f. Zip Code
20902 | | 10g. Citizen of What Country?
United States | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
Milton Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosa Unknown | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Willie Mae Smith - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
101 Odendhal Avenue, Gaithersburg, MD 20877 | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Date
11/8/96 | | 20d. Location - City or Town, State
Landover, Maryland | | |
| | 21. Signature of Funeral Service Licensee
John T. Stewart III | | | | 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N. E., Washington, D. C. | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):</p> <p>b. ARTERIOSCLEROTIC HEART DISEASE
Due to (or as a consequence of):</p> <p>c. _____
Due to (or as a consequence of):</p> <p>d. _____</p> | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CEREBRAL INFARCT; PROSTATE CANCER;
WASTING; CHRONIC RENAL FAILURE | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Martin C. Shargel M.D. | | | | 29c. License number
D08944 | | 29d. Date signed (Month, Day, Year)
11/3/96 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARTIN C. SHARGEL M.D. | | | | 3720 FARRAGUT AVE.
KENSINGTON, MD - 20895 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | 32. Registrar's Signature
John Stewart-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



ITEMS: 23 PART I, 27, PER State of Maryland / Department of Health and Mental Hygiene
MED FILM G-741 11/22/96 t.t

96 34872

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DEANDRIA SMITH | | 2. Date of Death
Month NOV. Day 3 Year 1996 | | 3. Time of Death
2119 PM |
| | 4e. Facility Name (If not institution, give street and number)
LAUREL REGIONAL HOSPITAL | | 4b. City, Town, or Location of Death
LAUREL | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
577-11-6802 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
27 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
MAR 16, 1969 | | 9. Birthplace (State or Foreign Country)
Wash., D.C. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location
Washington, D.C. | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. State
N/A | 10b. County
N/A | | | |
| | 10e. Street and Number
516 3rd Street, N.E. | | 10f. Zip Code
20002 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Driver | | 16b. Kind of Business/Industry
Car Rental |
| | 17. Father's Name (First, Middle, Last)
Ernest A. Smith | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Alston Smith | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Ernest Smith (Father) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
516 3rd Street, N.E. Washington, D.C. 20002 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Location - City or Town, State
11/8/96 Landover, Maryland |
| | 21. Signature of Funeral Service Licensee
M859 | | 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOMES
5538 Marlboro Pike, Forestville, Md 20747 | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24e. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | | |
| 28e. Date of Injury (Month, Day, Year)
28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 29e. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
O.C.M.E. | | | | | |
| 29d. Date signed (Month, Day, Year)
NOV. 4, 1996 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
THEODORE M. KING
111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 07 1996 | | | | | |
| 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

2

RECEIVED 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34873

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ursuline Juliet Stoyhoff

2. Date of Death

Month

Day

Year

October

25

1996

3. Time of Death

2215

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

468-01-1822

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 25, 1915

9. Birthplace (State or Foreign Country)

Montana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

659 Andrews Road

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In home

17. Father's Name (First, Middle, Last)

Alex Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Julia Murphy

19e. Informant's Name/Relationship (Type, Print)

Mr. Karl J. Stoyhoff (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

659 Andrews Road, Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cem. 11/5/96 Arlington, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bary R. DiGiuseppe

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-339923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or head failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Respiratory Acidosis. Due to Emphysema.

Approximate
Interval Between
Onset and Death

20 yrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastDue to (or as a consequence of):
Myocardial Ischemia, Subendocardial Infarction. 2 months.Due to (or as a consequence of):
Osteoarthritis.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

B.D. Parekh MD

29c. License number

D18424

29d. Date signed (Month, Day, Year)

Oct. 26 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

B.D. PAREKH MD. 1908 HARFORD ROAD FALLSTON MD. 21047.

31. Date filed (Month, Day, Year)

OCT 28 1996

32. Registrar's Signature

John Andrew Radell

State
Registrar

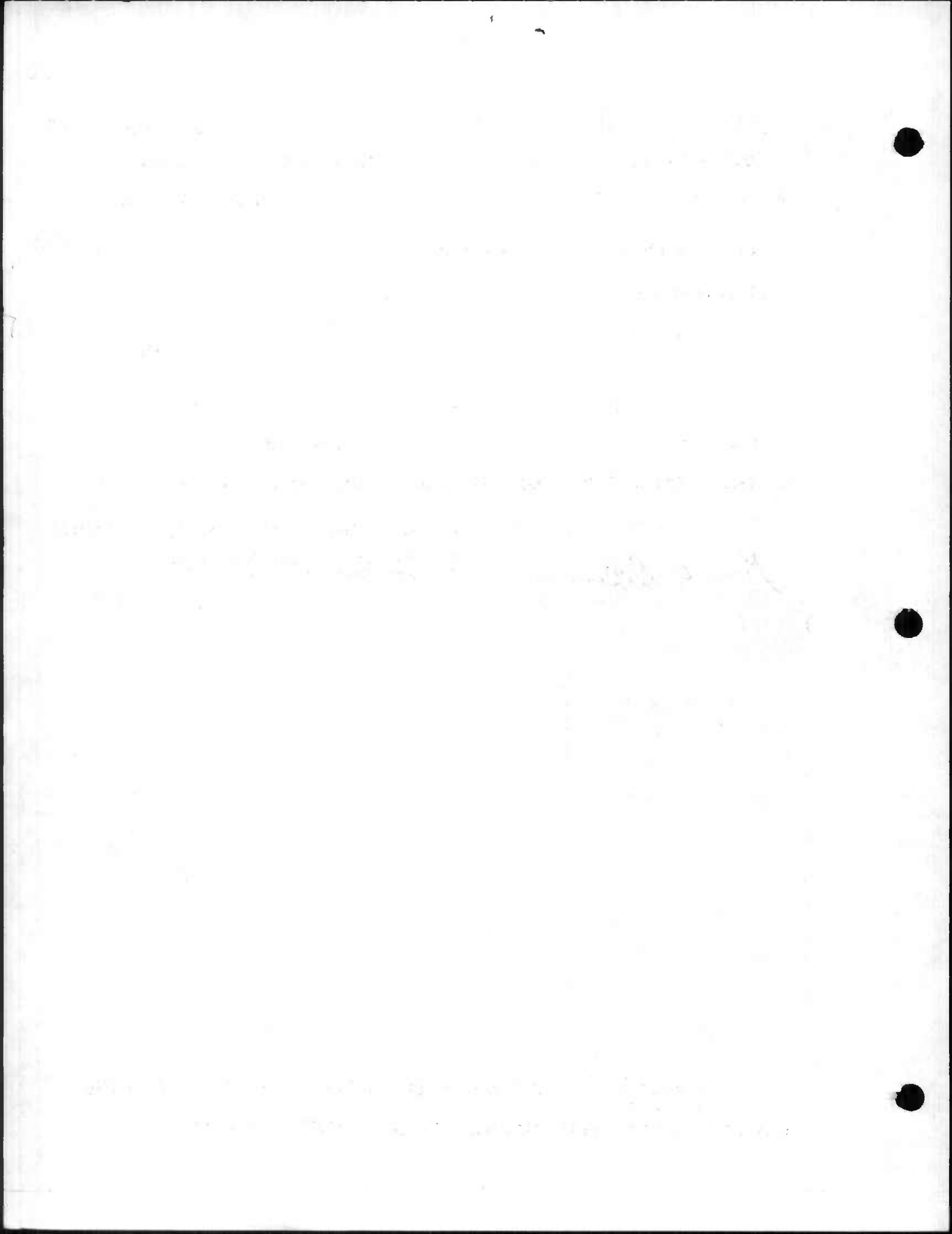
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 34874

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOHN BLAKE SIGLER | | | | 2. DATE OF DEATH
MONTH 11 DAY 7 YEAR 96 | | 3. TIME OF DEATH
0100 A.M. | |
| 4. SOCIAL SECURITY NUMBER
220-45-1435 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. 9 MONTHS 0 DAYS 0 | | 7. DATE OF BIRTH (Month, Day, Year)
2/7/96 | |
| 9a. FACILITY NAME (If not institution, give street and number)
MOUNT WASHINGTON PED HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Bel Air | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1105 Apt. A. Jeffrey Terrace | | | | 10f. ZIP CODE
21015 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
n/a | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Aaron Sigler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Angela Lynn Young | | | |
| 19a. INFORMANT'S NAME (Type/Print)
John A. Sigler | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1105 Apt. A. Jeffrey Terrace, Bel Air, Md. 21015 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Zion Church Cem. 11/9/96 Bel Air, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stephen A. Hughes</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE → CARDIAC ARREST 24 HRS
DUE TO (OR AS A CONSEQUENCE OF):
b. NEURODEGENERATIVE DISORDER - AS YET UNDIAGNOSED
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Bulatovic MD</i> | | 29c. LICENSE NUMBER
D44517 | | 29d. DATE SIGNED (Month, Day, Year)
11/7/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ANNAMARIA BULATOVIC, MT WASH PEDIATRIC HOSP, BALT, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 8 - 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. Sigler-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34875

| | | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Daniel Louis Stanley | | | | 2. Date of Death
Month: NOV Day: 8 Year: 96 | | | | 3. Time of Death
1:30P | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
218-16-5502 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV. 07, 1924 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10e. State
MD | | 10b. County
Dorchester | | 10c. City, Town or Location
Cambridge | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10f. Zip Code
21613 | | 10g. Citizen of What Country?
U.S. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Oyster Shucker | | | | 16b. Kind of Business/Industry
Seafood | |
| | 17. Father's Name (First, Middle, Last)
Daniel Richard Stanley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Leona Robbins | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
CARLOS Kane | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1118-Maces Lane - Cambridge, Maryland 21613 | | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethel Cemetery | | 20c. Location - City or Town, State
Cambridge, Maryland | | 20d. Date
11/14/96 | |
| | 21. Signature of Funeral Service Licensee
Danelle C. Henry | | | | 22. Name and Address of Facility
HENRY FUNERAL HOME
510 Washington St. Cambridge, Maryland 21613 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.
Immediate Cause (Final disease or condition resulting in death)
Congestive Heart failure | | | | | | | | Approximate Interval Between Onset and Death
months | |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
dilated cardiomyopathy
renal failure
Hypothyroidism | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Heart Block.
valvular heart disease. | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27b. Dfd tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
SADP | | | | 29c. License number
D46020 | |
| 29d. Date signed (Month, Day, Year)
11/8/96 | | | | | | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Syed Ali, M.D. 606 Dutchman's Lane Easton, MD 21601 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 12 1996 | | | | 32. Registrar's Signature
John Davidson-Randall | | | | | |

AMENDED #5, SEL
ALLEGANY CTY. 11/1/96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34876

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 sel

State Registrar

Physician / Medical Examiner

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
WALTER SCOTT SHREVE, IV | | 2. Date of Death
Month OCTOBER Day 30 Year 1996 | | 3. Time of Death
0130AM | |
| 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL E.R. | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| 5. Social Security Number
216-92-3324
235-72-8275 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
24 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
May 23, 1972 | | 9. Birthplace (State or Foreign Country)
MD | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
Washington | | 10c. City, Town or Location
Hagerstown | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
351 Liberty Street | | 10f. Zip Code
21740 | |
| 10g. Citizen of What Country?
USA | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Case Worker | | 16b. Kind of Business/Industry
Justice Juvenile Svcs | | 17. Father's Name (First, Middle, Last)
Walter S. Shreve, III | |
| 18. Mother's Name (First, Middle, Maiden Surname)
R. Jean (Gray) | | 19a. Informant's Name/Relationship (Type, Print)
R. Jean Shreve--mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11109 Deer Ridge Road NW; LaVale, MD 21502 | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park | | 20c. Date
11/02 | |
| 20d. Location - City or Town, State
Cumberland, MD | | 21. Signature of Funeral Service Licensee
<i>James F. Scarpelli</i> | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE INJURIES
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
10 30 96 | | 28b. Time of Injury
1205 AM | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
TRUCK OR TRAILER
DRIVEN OVER CAR STRUCK PARKED | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
RT144 ALLEGANY CO MARYLAND | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
<i>Raymond McNeill</i> | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
OCTOBER 31, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARYSAW S. KOSOW 1111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 01 1996 | | 32. Registrar's Signature
<i>John Davidson Randall</i> | | | |

96 34877

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)
Jose Pagan Salgado, Jr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOV 5 1996 | | 3. TIME OF DEATH
9:10 P.M. | |
| 4. SOCIAL SECURITY NUMBER
582-09-6438 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
65 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
July 3, 1931 | | 8. BIRTHPLACE (State or Foreign Country)
Puerto Rico | |
| 9a. FACILITY NAME (If not institution, give street and number)
14800 Faulkner Rd. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Marydel | | 9c. COUNTY OF DEATH
Caroline | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Marydel | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
14800 Faulkner Rd. | | | |
| 10f. ZIP CODE
21649 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify Puerto Rican | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +)
11 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
landscaper | | 16b. KIND OF BUSINESS/INDUSTRY
Delaware Excavation | |
| 17. FATHER'S NAME (First, Middle, Last)
Jose Pagan, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Eufemia Salgado | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Carmen M. Salgado | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14800 Faulkner Rd., Marydel, MD 21649 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Greensboro Cemetery 11/9 | | 20c. LOCATION — City or Town, State
Greensboro, Maryland | | 20d. DATE
11/9 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Freegle-Helfenbein Funeral Home
106 W. Sunset Ave. Box 160
Greensboro, MD 21639 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PANCREATIC CANCER
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death: Chronic
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.
INSULIN-DEPENDENT DIABETES | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>C. E. Jensen MD Deputy M.E.</i> | | | | 29c. LICENSE NUMBER
D14664 | | 29d. DATE SIGNED (Month, Day, Year)
11/5/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
C. E. JENSEN MD, PO Box 690, DENTON MD 21629 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV - 8 '96 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34878

| | | | | | |
|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Lee Schultz, Sr. | | 2. Date of Death
Month October Day 31 , Year 1996 | | 3. Time of Death
6:20AM |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital at Easton | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot |
| Funeral
Director | 5. Social Security Number
220-26-8823 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
February 26, 1927 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
Caroline |
| | 10c. City, Town or Location
Denton | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
6216 Laurel Grove Road | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify:
Caucasian | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 HS Grad.
College (1-4or 5+) College | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Owner/Operator |
| | 17. Father's Name (First, Middle, Last)
Leo Otto Schultz | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Callahan | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Mary Jane Schultz Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6216 Laurel Grove Road, Denton, Maryland 21629 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Denton Cemetery | | 20c. Location - City or Town, State
Denton, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Moore Funeral Home, P.A.
PO Drawer B, Denton, Maryland 21629 | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Years | | Approximate Interval Between Onset and Death
Years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
M | | 28b. Time of Injury
11:00 | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D24769 | |
| 29d. Date signed (Month, Day, Year)
10/31/96 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
L. Thomas Divilio, M.D., PO Box 822, Easton, Maryland 21601 | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
NOV - 4 '96 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 34879**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY VIRGINIA SHUCK

2. Date of Death

Month 11, Day 11, 1996 Year

3. Time of Death

10:30 p.m.

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

217-18-4553

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 10, 1923

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

129 1/2 Polk Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Ret. District Court

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

David Lloyd Roller

18. Mother's Name (First, Middle, Maiden Surname)

Ellie (Crowfis)

19a. Informant's Name/Relationship (Type, Print)

Susan Tressler--daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 45; Oldtown, MD 21555

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

11/12

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure
Due to (or as a consequence of):b. Pneumonia
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days
6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Steven B. Bessinger

29c. License number

D50520

29d. Date signed (Month, Day, Year)

11-12-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

902 Sutton Dr. Suite 307 Cumberland, MD

31. Date filed (Month, Day, Year)

NOV 12 1996

32. Registrar's Signature

John Davidson

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


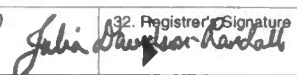
Certificate of Death

Reg. No.

96 34880

| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George Irvin Snyder | | | | 2. Date of Death
Month November Day 3 Year 1996 | | 3. Time of Death
3:45 PM | |
| | 4a. Facility Name (If not institution, give street and number)
13009 Irvin Street, N.W. | | | | 4b. City, Town, or Location of Death
Mount Savage | | 4c. County of Death
Allegany | |
| Funeral
Director | 5. Social Security Number
215-10-1252 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
97 Yrs. | | 8. Date of Birth (Month, Day, Year)
23-Apr-99 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Allegany | | 10c. City, Town or Location
Mount Savage | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
13009 Ervin Street N.W. | | 10f. Zip Code
21545- | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Miner | | 16b. Kind of Business/Industry
Coal Mining | | 17. Father's Name (First, Middle, Last)
Milton Snyder | |
| | 17. Mother's Name (First, Middle, Maiden Surname)
Caroline Bittner | | 19a. Informant's Name/Relationship (Type, Print)
May V. Snyder Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13009 Irvin Street, N.W. Mount Savage Maryland 21545- | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Savage Methodist Cemetery | | 20c. Date
06-Nov-96 | | 20d. Location - City or Town, State
Mount Savage, Maryland | | 21. Signature of Funeral Service Licensee
 | |
| | 22. Name and Address of Facility
Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. congestive Heart Failure
Due to (or as a consequence of):
b. Coronary artery disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

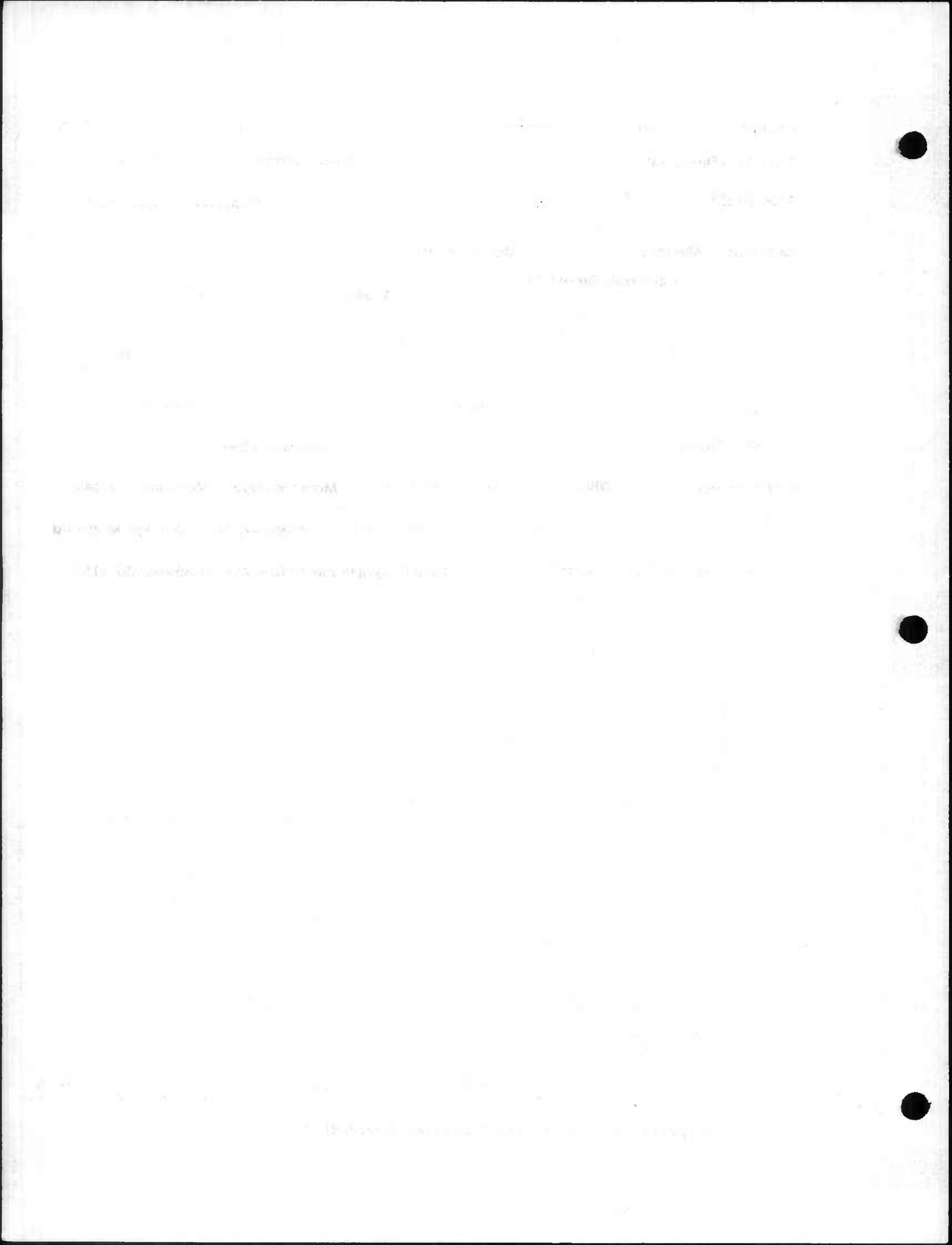
Approximate Interval Between Onset and Death
weeks
years | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | |
| | 29c. License number
1703459 | | 29d. Date signed (Month, Day, Year)
Nov. 4, 1996 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
R. Espina, M.D., 902 Seton Drive, Cumberland, Maryland 21502 | | 31. Date filed (Month, Day, Year)
NOV 04 1996 | |
| 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

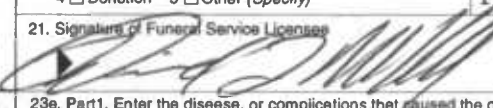
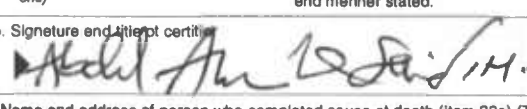
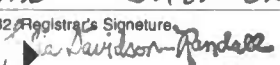


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34881

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
COLEMAN SMITH | | 2. Date of Death
Month: OCTOBER Day: 29 Year: 1996 | | 3. Time of Death
6:40 PM |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | 4b. City, Town, or Location of Death
CLINTON | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
405-40-6043 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
62 Yrs. | If Under 1 Year
Months: Days: | If Under 24 Hrs.
Hours: Min. |
| | 8. Date of Birth (Month, Day, Year)
Feb. 22, 1934 | | 9. Birthplace (State or Foreign Country)
Kentucky | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | | 10b. County
Prince Georges | | 10c. City, Town or Location
Upper Marlboro | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
7300 Loanda Drive | | 10f. Zip Code
20772 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 5+): | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | | 16b. Kind of Business/Industry
Tire & Auto Retail | |
| 17. Father's Name (First, Middle, Last)
Coleman A. Smith | | 18. Mother's Name (First, Middle, Maiden Surname)
Mattie Philips | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joy D. Smith / Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7300 Loanda Drive, Upper Marlboro, Maryland 20772 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
Brentwood, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. Massive Myocardial Infarction
Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease
Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 10%; text-align: center;"> <p>Approximate interval Between Onset and Death</p> </div> </div> | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify): | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D34140 | | 29d. Date signed (Month, Day, Year)
10/30/1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ABDEL- EL SAID 3261 OLD Washington Rd. Waldorf Maryland 20692 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34882

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY McDONALD STEWART

2. Date of Death

Month Day Year
NOV. 2, 1996

3. Time of Death

11:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GOLDEN OAKS NURSING HOME

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

5. Social Security Number

240-32-4890

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT. 6, 1906

9. Birthplace (State or Foreign Country)

S. CAROLINA

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

COLLEGE PARK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5004 NAVAHOE ST.

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

CHARLIE McDONALD

18. Mother's Name (First, Middle, Maiden Surname)

NANCY STACKHOUSE

19a. Informant's Name/Relationship (Type, Print)

MARY SELLERS/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

11/7

20c. Location - City or Town, State

N.C.

PLEASANT GROVE BAPTIST CHURCH CEM. ST. PAULS,

21. Signature of Funeral Service Licensee

W. W. Chambers M00091

22. Name and Address of Facility

W. W. CHAMBERS CO., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ASPIRATION PNEUMONIA

DAYS

Due to (or as a consequence of):

b. ORGANIC BRAIN SYNDROME

YRS.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

injury

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25422

29d. Date signed (Month, Day, Year)

NOV. 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. MAGGIN M.D.,

LAUREL, MD. 20708

State
Registrar

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY

REPORT OF THE
COMMISSIONER OF THE
BUREAU OF CHEMISTRY

FOR THE YEAR
1900-1901
IN RESPONSE TO
A RESOLUTION OF THE
HOUSE OF REPRESENTATIVES
PASSED MAY 12, 1890
AND A RESOLUTION OF THE
SENATE PASSED MAY 12, 1890

BY
J. H. MANN
COMMISSIONER

WASHINGTON
GOVERNMENT PRINTING OFFICE
1901

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY

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COMMISSIONER OF THE
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BY
J. H. MANN
COMMISSIONER
WASHINGTON
GOVERNMENT PRINTING OFFICE
1901

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34883

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Stoner

2. Date of Death

Month
Nov.Day
5Year
1996

3. Time of Death

3:10 A.M.

4a. Facility Name (If not institution, give street and number)

Manor Care - Fernwood

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-05-9672

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Nov. 29, 1901

10. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. State

None

Usual Residence of Decedent

10a. State

None

10b. County

None

10c. City, Town or Location

Washington, D. C.

10e. Street and Number

5900 31st Place N. W.

10f. Zip Code

20015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk of Archives

16b. Kind of Business/Industry

Indian Supply Mission

Indian Government

17. Father's Name (First, Middle, Last)

Samuel Arthur Stoner

18. Mother's Name (First, Middle, Maiden Surname)

Virgie Florence Tisinger

19a. Informant's Name/Relationship (Type, Print)

Mary Belle Rickert - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11910 Jubal Early Court Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

11/7/96

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Joseph C. Wan

22. Name and Address of Facility

Joseph Gawler's Sons

5130 WI Ave. N.W. Washington, D.C. 20016

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

2 months

b. Severe Aortic Stenosis

Due to (or as a consequence of):

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

L. Albitol, MD

29c. License number

D31319

29d. Date signed (Month, Day, Year)

November 6, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Loreto S. Albitol, M. D. 8218 Wisconsin Ave. #105 Bethesda, MD 20814

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34884

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANK G.

STERRETT

2. Date of Death

Month Day Year
OCT. 30, 1996

3. Time of Death

7:00 A.M.

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

5008 KEOKUK STREET

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

577-52-2533

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10/30/13

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5008 KEOKUK STREET

10f. Zip Code

20816

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

BUILDER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

WILLIAM DENT STERRETT

18. Mother's Name (First, Middle, Maiden Surname)

IDA TOPPING GUM

19a. Informant's Name/Relationship (Type, Print)

PATRICIA STERRETT/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5008 KEOKUK STREET BETHESDA, MD 20816

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. COMFORT CREMATORY

Date

10/31/96

20c. Location - City or Town, State

ALEXANDRIA, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH GAWLER'S SONS, INC.

5130 WI AVE., N.W. WASHINGTON, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARCINOMA OF PROSTATE

Approximate Interval Between Onset and Death

3 YEARS

a. Due to (or as a consequence of):

UREMIA

3 YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

10200

29d. Date signed (Month, Day, Year)

OCT. 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JACK SEGAL 5454 WISCONSIN AVE., CHEVY CHASE, MD. 20815

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34885

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NAOMI SUGAR | | | | 2. Date of Death
Month: NOV. 6, 1996 Day: Year: | | 3. Time of Death
04:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST NURSING CENTER | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
577-50-9942 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | 8. Date of Birth (Month, Day, Year)
JULY 13, 1916 | 9. Birthplace (State or Foreign Country)
WASHINGTON D.C. | | | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
MONTGOMERY | 10c. City, Town or Location
ROCKVILLE | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
10500 ROCKVILLE PIKE #1404 | | 10f. Zip Code
20852 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SECRETARY | | 16b. Kind of Business/Industry
MEDICAL | | | |
| | 17. Father's Name (First, Middle, Last)
MORRIS VIGDERHOUSE | | | 18. Mother's Name (First, Middle, Maiden Surname)
JENNIE SUNSHINE | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
SAMUEL J. SUGAR (HUSBAND) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10500 ROCKVILLE PIKE #1404 ROCKVILLE, MARYLAND 20852 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH SHOLOM CEMETERY | | 20c. Location - City or Town, State
11/8/96 CAPITOL HEIGHTS, MD | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
e. CARDIAC ARREST
Due to (or as a consequence of):
b. CARCINOID TUMOR OF SMALL BOWEL
Due to (or as a consequence of):
c. WITH ENTEROCUTANEOUS FISTULA
Due to (or as a consequence of):
d. MALNUTRITION FROM MALABSORPTION | | | | | | | MINUTES
17 YEARS
5 MONTHS
1 MONTH |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29e. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number
B93133 | | 29d. Date signed (Month, Day, Year)
11/6/96 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JEROME L. SANDLER, M.D. F.A.C.S. 10103 GEORGIA AVENUE #205 SILVER SPRING, MD | | | | | | | 20907 | |
| 31. Date filed (Month, Day, Year)
NOV 08 1996 | | 32. Registrar's Signature
Jia Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34886

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA SEISSLER

2. Date of Death

Month Day Year
NOVEMBER 5, 1996

3. Time of Death

7:20 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

112-07-8529

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
OCT. 18, 1917

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

FLORIDA

10b. County

BROWARD

10c. City, Town or Location

MARGATE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1025 COUNTRY CLUB DRIVE

10f. Zip Code

33063

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

DAVID WINTER

18. Mother's Name (First, Middle, Maiden Surname)

POLI SCHECHTER

19a. Informant's Name/Relationship (Type, Print)

ALAN SEISSLER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19009 SEDLEY TERRACE - GAITHERSBURG, MARYLAND 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WELLWOOD CEMETERY

Date

11/8/96

20c. Location - City or Town, State

PINELAWN, NEW YORK

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY Artery disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D37024

29d. Date signed (Month, Day, Year)

November 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID G. SNOOR 9901 Medical Center Drive Rockville, Md. 20850

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34887

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SIDNEY SCHECHTER | | | | 2. Date of Death
Month NOVEMBER Day 6 Year 1996 | | 3. Time of Death
9:30 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
ROCKVILLE NURSING CENTER | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | | |
| Funeral
Director | 5. Social Security Number
058-05-6043 | | 6. Sex
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
95 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUG. 2, 1901 | 9. Birthplace (State or Foreign Country)
NEW YORK | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
ROCKVILLE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
303 ADCLARE ROAD | | | | 10f. Zip Code
20850 | | 10g. Citizen of What Country?
UNITED STATES | | |
| | 11. Marital Status
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MANUFACTURER | | 16b. Kind of Business/Industry
CLOTHING | | | | |
| | 17. Father's Name (First, Middle, Last)
MAYER SCHECHTER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BESSIE GELLER | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
DR. ALAN SCHECHTER (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5405 BEECH AVENUE - BETHESDA, MARYLAND 20814 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. HEBRON CEMETERY | | Date
11/10/96 | | 20c. Location - City or Town, State
FLUSHING, NEW YORK | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. GASTROINTESTINAL BLEEDING
Due to (or as a consequence of):
b. ARTEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | Approximate Interval Between Onset and Death
48 HOURS
YEARS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D19785 | | 29d. Date signed (Month, Day, Year)
November 6th, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRAUKE WESTPHAL - 809 VEIRS MILL ROAD - ROCKVILLE, MARYLAND 20851 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 08 1996 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34888

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth James Simmons

2. Date of Death

Month

Day

Year

November 06 1996

3. Time of Death

11:10 AM

4. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

014-32-8154

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 20, 1944

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5225 Pooks Hill Road #1721N

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Military Contractor

17. Father's Name (First, Middle, Last)

Lloyd Simmons

18. Mother's Name (First, Middle, Maiden Surname)

Rose Rock

19a. Informant's Name/Relationship (Type, Print)

Debra J. Alessandro

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Grove Street, Tewksbury, MA 01876

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

11-7-96

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. METASTATIC NONSMALL CELL LUNG
CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles Henderson MD

29c. License number

D37236

29d. Date signed (Month, Day, Year)

NOVEMBER 06, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Henderson MD 9707 MEDICAL CENTER DRIVE

ROCKVILLE MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

NOV 08 1996

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34889

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wilton M. Schrider

2. Date of Death

Month Day Year
October 29, 1996

3. Time of Death

9:25 AM

4a. Facility Name (If not institution, give street and number)

14532 Perrywood Drive

4b. City, Town, or Location of Death

Burtonsville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

714-07-9351

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 20, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Burtonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14532 Perrywood Drive

10f. Zip Code

20866

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Sales

17. Father's Name (First, Middle, Last)

James E. Schrider

18. Mother's Name (First, Middle, Maiden Surname)

Theresa McCauley

19a. Informant's Name/Relationship (Type, Print)

Elizabeth E. Schrider

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14532 Perrywood Drive Burtonsville, Maryland 20866

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John's Cemetery

Date

11/2/96 Forest Glen, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James S. Dooly

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancytopenia

Approximate Interval Between Onset and Death

1 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bone marrow metastases

18 mo

c. Prostate cancer

18 mo

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Peter B. Sherer MD

29c. License number

D21910

29d. Date signed (Month, Day, Year)

October 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, MD 20906

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

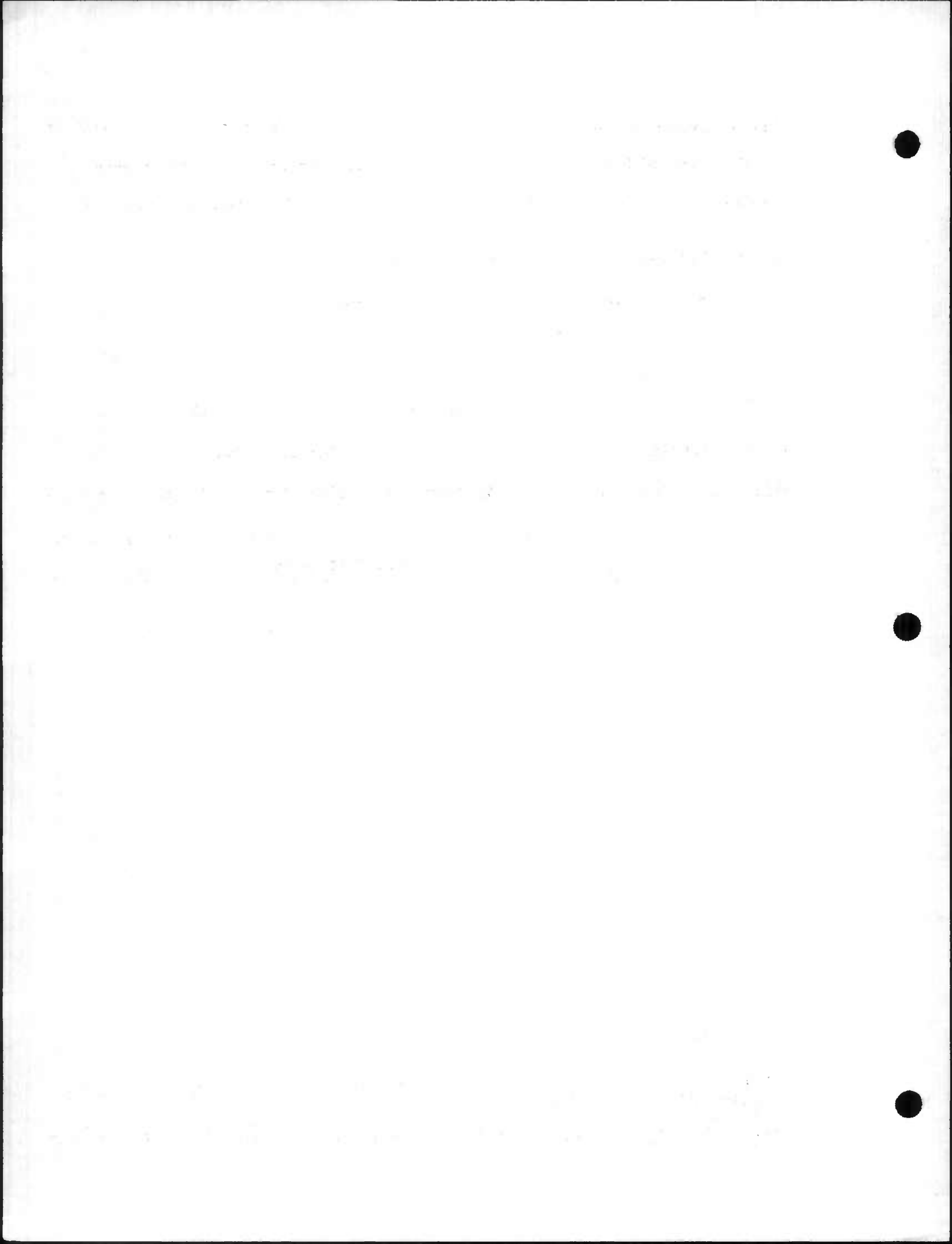
Ma Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34890

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Alicia Shea

2. Date of Death

October 27, 1996

3. Time of Death

7:30 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

3372 Chiswick Court; Apt. 1B

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-36-2609

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 27, 1913 New York

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3372 Chiswick Court, Apt. 1B

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Jere

Shea

18. Mother's Name (First, Middle, Maiden Surname)

Josephine

Bennett

19a. Informant's Name/Relationship (Type, Print)

Francis Yeatman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4405 East-West Highway, 6th floor, Bethesda, Md. 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory

Date

11-2-96

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensed

James J. Holland

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md. 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ACUTE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Francis C. Mayhew

29c. License number

D07099

29d. Date signed (Month, Day, Year)

Oct 31 96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis C Mayhew 1025 Fernwood Rd Bethesda MD 20814

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

*Davidson-Randall*State
Registrar

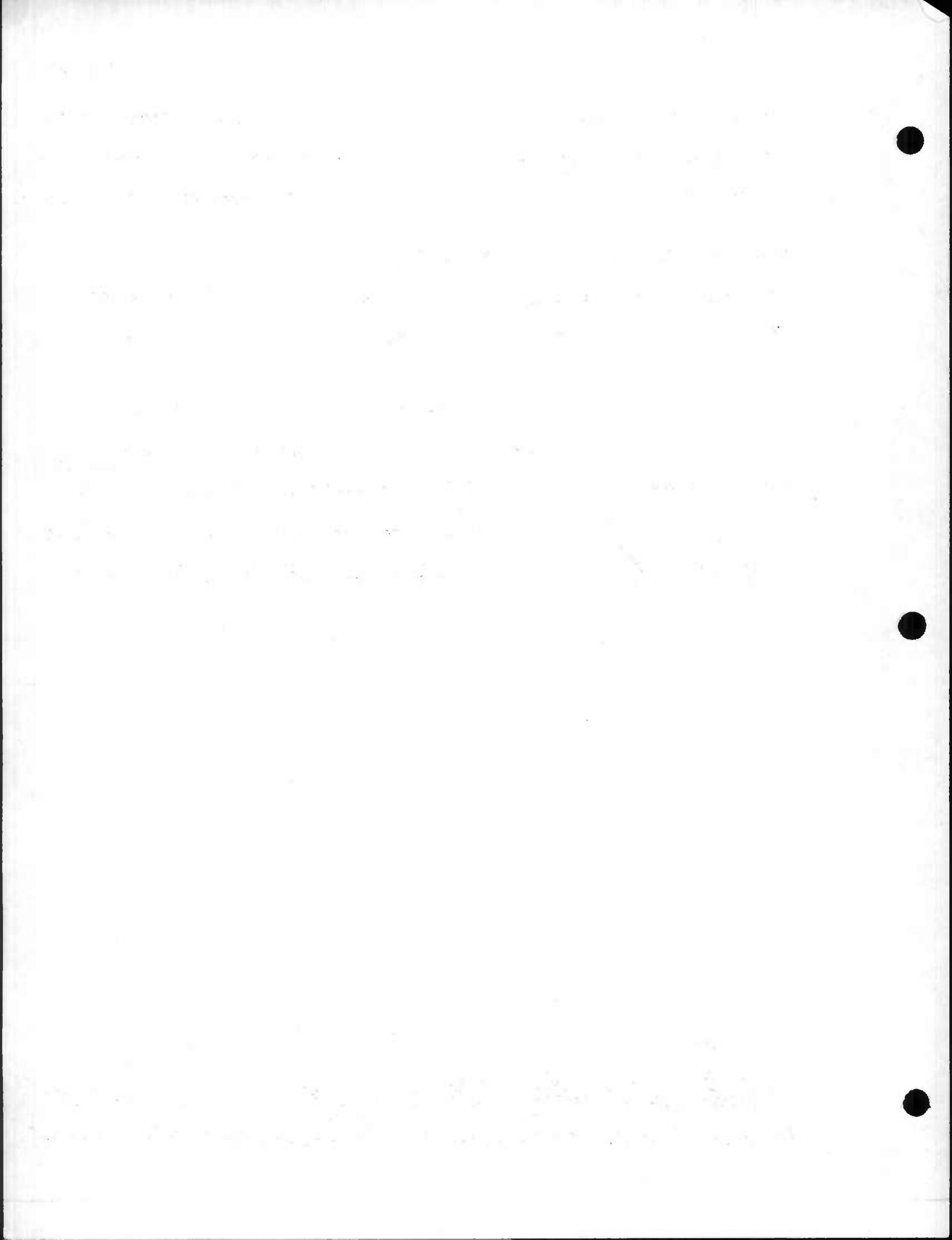
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34891

| | | | | | | | | |
|---|--|---|--|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gloria F. Shaw | | | | 2. Date of Death
Month October Day 31 , Year 1996 | | 3. Time of Death
7:40 A. | |
| | 4a. Facility Name (If not institution, give street and number)
11510 Blueridge Drive | | | | 4b. City, Town, or Location of Death
Beltsville | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
578-32-8198 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 2, 1923 | |
| | | | | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| 9. Birthplace (State or Foreign Country)
Washington, D.C. | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Beltsville | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
11510 Blueridge Drive | | | | 10f. Zip Code
20705 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | | 16b. Kind of Business/Industry
Admitting Office
Holy Cross Hospital | |
| 17. Father's Name (First, Middle, Last)
Romeo E. Fagiolo | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosina Sari | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lester B. Shaw (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as #10 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | Date
11/4/1996 | | 20c. Location - City or Town, State
Silver Spring, Maryland | |
| 21. Signature of Funeral Service Licensee
<i>Donald V. Borgwardt</i> | | | | 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland 20705 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. acute myocardial infarction Terminal
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>George F. Sengstack</i> | | | | 29c. License number
D12121 | | 29d. Date signed (Month, Day, Year)
October 31, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George F. Sengstack, M.D. 3929 Ferrara Drive Wheaton, Maryland 20906 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

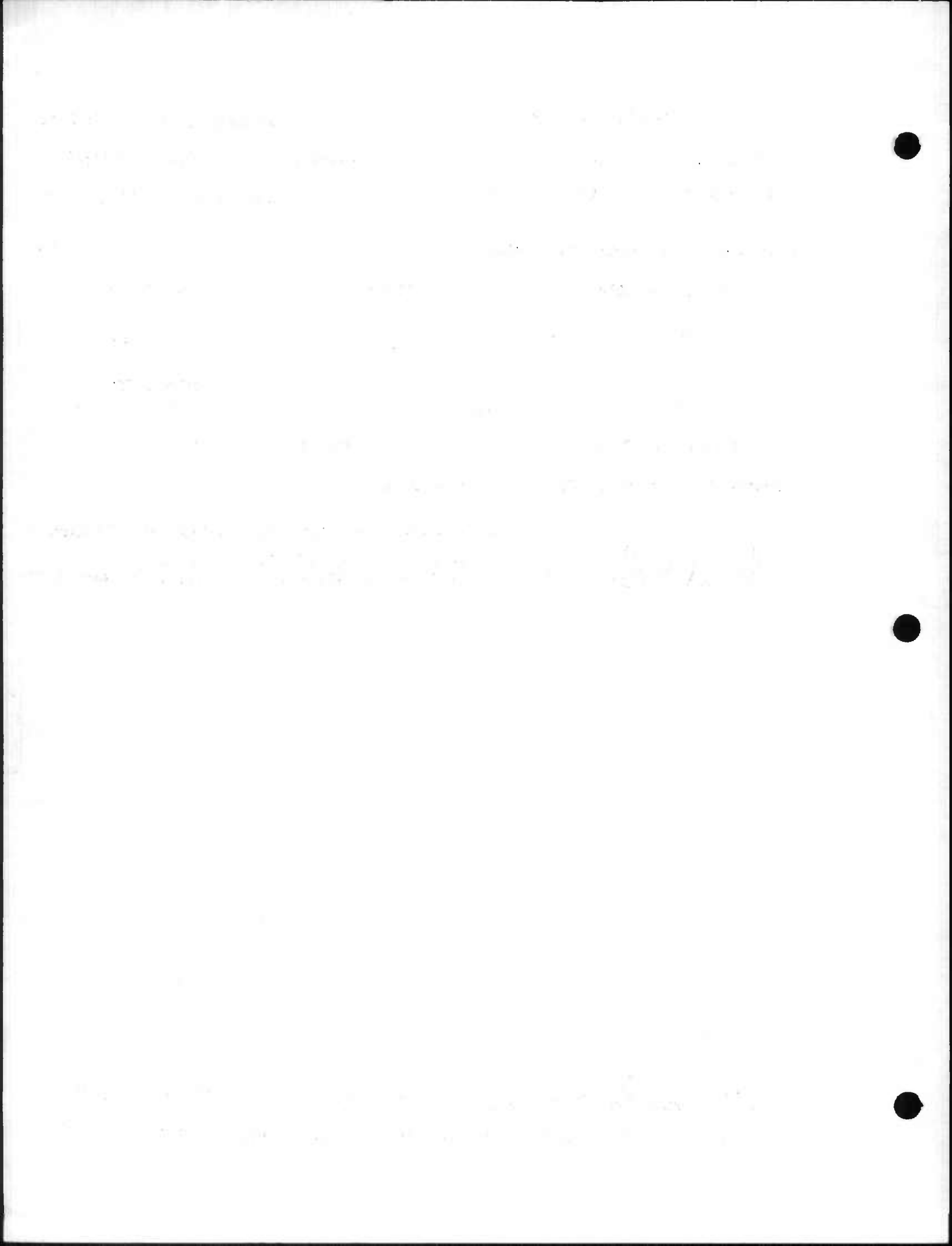
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34892

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Elizabeth Sheridan

2. Date of Death

November 1, 1996

3. Time of Death

8:15 A.M.

4a. Facility Name (If not institution, give street and number)

Randolph Hills Nursing Center

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

360-14-7014

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 28, 1903

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9915 Pomona Drive

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Alfred Hickes

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Welch

19a. Informant's Name/Relationship (Type, Print)

Marilou S. Majowicz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9915 Pomona Drive Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

11/2/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Cerebral Ischemia

Due to (or as a consequence of):

10 Mins.

b. Cerebral Artery Occlusion

Due to (or as a consequence of):

10 Mins.

c. Cerebral Arteriosclerosis

Due to (or as a consequence of):

10 Years

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D 02047

29d. Date signed (Month, Day, Year)

November 1, 1996

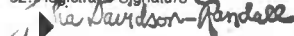
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Connor, M.D. 6000 Executive Blvd. Suite 300, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34893
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry Schietroma

2. Date of Death

Month

Day

Year

4

6

96

3. Time of Death

3:04 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

128-03-2985

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 10, 1917

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland Montgomery

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10017 Burnett Avenue

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1941-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

New York City

Port Authority

17. Father's Name (First, Middle, Last)

Ettore Schietroma

18. Mother's Name (First, Middle, Maiden Summa)

Theresa Bizzari

19a. Informant's Name/Relationship (Type, Print)

Teresa Glynn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10017 Brunette Avenue, Silver Spring, Maryland 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven

Date

11/9/96 Valhalla, New York

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Steven D. Stumel

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd.W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Aspiration Pneumonia

11/6/96

Due to (or as a consequence of):

b. Acute Respiratory Failure

4/6/96

Due to (or as a consequence of):

c. COPD

1990

Due to (or as a consequence of):

d. ASVD

1990

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LHF

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ABP Juh M

29c. License number

D17729

29d. Date signed (Month, Day, Year)

11/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B.B. Patrick MD 9221 Colesville Rd SJ, Md 20910

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

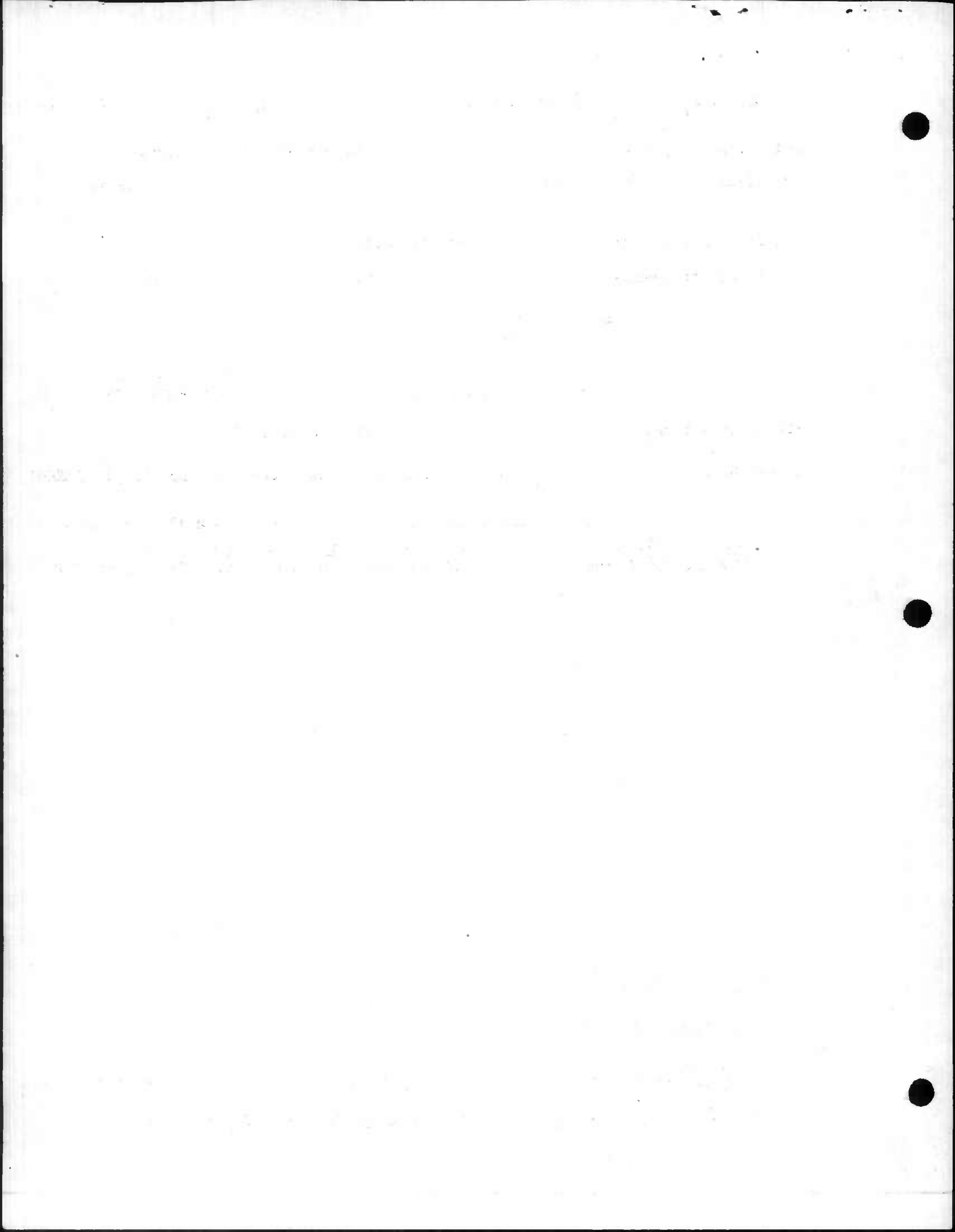
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34894

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cecelia J. Sewell

2. Date of Death

November 5, 1996

3. Time of Death

5:00 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

817 Quince Orchard Blvd, #14

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

MONTGOMERY

5. Social Security Number

216-82-9225

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 19, 1963

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

817 Quince Orchard Blvd, #14

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Accountant Rep.

16b. Kind of Business/Industry

T.R.I. Corp.

17. Father's Name (First, Middle, Last)

William L. Budd

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Sewell

19a. Informant's Name/Relationship (Type, Print)

Lucille S. Budd (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

817 Quince Orchard Blvd, Gaithersburg, Md 20877

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ash Memorial Cem.

Date

11/12

20c. Location - City or Town, State

Sandy Spring, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snowden Funeral Home P.A. 20850
246 N. Washington St, Rockville, Md23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Wasting Syndrome

Due to (or as a consequence of):

1 yr.

b. Acquired Immunodeficiency Syndrome

Due to (or as a consequence of):

2 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bibasilar Pneumonia

Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

D35404

29d. Date signed (Month, Day, Year)

NOVEMBER 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Sauri, M.D., 9715 Medical Center Dr., Ste 201, Rockville, MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 34895

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Elizabeth Pearce Todd | | | | 2. DATE OF DEATH
MONTH 10 DAY 29 YEAR 96 | | 3. TIME OF DEATH
8:15pm M | |
| 4. SOCIAL SECURITY NUMBER
216-12-1350 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
98 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec 1, 1897 | |
| 9a. FACILITY NAME (If not institution, give street and number)
William Hill Health Care Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Talbot | | 10c. CITY, TOWN OR LOCATION
Easton | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
204 Brookletts Avenue | | | | 10f. ZIP CODE
21601 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Bookkeeper | | 16b. KIND OF BUSINESS/INDUSTRY
Banking | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles C. Pearce | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Conlyn | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Daniel G. Higgins, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P. O. Box 31, Claiborne, Maryland 21624 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Spring Hill Cemetery 11/5/96 | | 20c. LOCATION — City or Town, State
Easton, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Harrison E. Leonard</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Harrison E. Leonard Funeral Home 21663
312 South Talbot Street, St. Michaels, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Partial small bowel obstruction
DUE TO (OR AS A CONSEQUENCE OF):
b. Miles resection - rectal carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate interval Between Onset and Death
10-18-96
1967 | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
None | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Robert W. Trever, M.D. | | | | 29c. LICENSE NUMBER
D10938 | | 29d. DATE SIGNED (Month, Day, Year)
10-30-96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert W. Trever, M.D., 7696 Ocean Gateway, EASTON, MD 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV - 7 1996 | | | | 32. REGISTRAR'S SIGNATURE
<i>Schia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

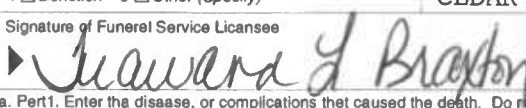
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

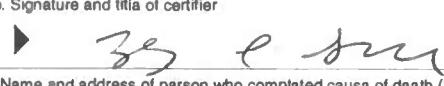
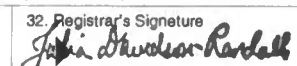
Certificate of Death

Reg. No.

96 34896

| | | | | | | | | | | |
|--|--|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARJORIE TATE | | | | 2. Date of Death
Month Day Year
OCTOBER 30, 1996 | | 3. Time of Death
07:09 AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
MALCOLM GROW MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
CAMP SPRINGS | | 4c. County of Death
PRINCE GEORGE'S | | | |
| Funeral
Director | 5. Social Security Number
171-16-1828 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 12, 1913 | | 9. Birthplace (State or Foreign Country)
ROANOKE, VIRGINIA | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
PRINCE GEORGE'S | | 10c. City, Town or Location
BRADBURY HEIGHTS | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
4345 SOUTHERN AVE. | | | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
PVT. INDUSTRY | | | | | | |
| 17. Father's Name (First, Middle, Last)
UNKNOWN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DOROTHY TATE/ DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4345 SOUTHERN AVE. BRADBURY HTS., MD 20743 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CEDAR HILL CEMETERY | | 20c. Location - City or Town, State
11-4-96 SUITLAND, MD | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME
4308 SUITLAND RD. SUITLAND, MD 20746 | | | | | | | | |
| 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOGENIC SHOCK
Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
MD-042806-E | | 29d. Date signed (Month, Day, Year)
OCTOBER 30, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
THOMAS C. GRAU, MAJ, USAF, MC | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ANDREWS AIR FORCE BASE, MD 20762-6600 | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 06 1996 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

96 34897

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
NETTIE A. THOMAS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOV 1 1996 | | 3. TIME OF DEATH
9:55 AM | |
| 4. SOCIAL SECURITY NUMBER
579-28-7443 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
January 22, 1901 | |
| 8. BIRTHPLACE (State or Foreign Country)
Tennessee | | | | 9a. FACILITY NAME (If not institution, give street and number)
Livingston Health Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH
Fort Washington | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Fort Washington | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
12021 Livingston Road | |
| 10f. ZIP CODE
20744 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John F. Turner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Angeline (Unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
June Collins - Daughter-in-law | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11316 Tippet Road, Clinton, Maryland 20735 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. DATE
11/4/96 | | 20d. LOCATION — City or Town, State
Brentwood, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
W.B. Geise | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, Md. 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Insufficiency | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Chronic Obstructive Lung Disease | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Dr. Negla M.R. | | | | 29c. LICENSE NUMBER
D07348 | | 29d. DATE SIGNED (Month, Day, Year)
NOV. 1, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
11701 LIVINGSTON RD. FORT WASHINGTON MD. 20744 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 04 1996 | | 32. REGISTRAR'S SIGNATURE
John Andrew Russell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34898

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Louise F Thomasson | | | | 2. Date of Death
Month Day Year
October 29, 1996 | | 3. Time of Death
9:20 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
National Lutheran Home | | | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
Montgomery County | | |
| Funeral
Director | 5. Social Security Number
579-54-9904 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT. 4, 1908 | | 9. Birthplace (State or Foreign Country)
OHIO | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
D.C. | 10b. County
NONE | 10c. City, Town or Location
WASHINGTON, DC | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
2704 31st STREET, S.E. | | | 10f. Zip Code
20020 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SECRETARY | | | 16b. Kind of Business/Industry
DEPT. OF NAVY | | | |
| | 17. Father's Name (First, Middle, Last)
SWAN FREED | | | | 18. Mother's Name (First, Middle, Maiden Summa)
ALMA ELFRIDE JOHNSON | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
REV.DR. REICHARD | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9701- VEIRS DRIVE, ROCKVILLE, MD. 20850 | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY-11/1/96-ALEXANDRIA, VA. | | Data | | 20c. Location - City or Town, State | | |
| | 21. Signature of Funeral Service Licensee
W.M. Hysong | | | 22. Name and Address of Facility
HYSONG CO. FUNERAL HOME
1300- N STREET, N.W., WASH., DC | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Left ventricular failure Due to (or as a consequence of):
b. pneumonia Due to (or as a consequence of):
c. atherosclerotic heart disease Due to (or as a consequence of):
d. Chronic obstructive pulmonary disease years.
Approximate Interval Between Onset and Death
few months
2 days
years | | | | | | | | |
| | 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Charles W. Karesch | | 29c. License number
D21726 | | 29d. Date signed (Month, Day, Year)
October 30, 1996 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. CHARLES W. KARESH- 1 N. MAIN STREET, MT. AIRY, MD. | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 05 1996 | | 32. Registrar's Signature
John A. Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34899

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELLIS DAVID THOMAS

2. Date of Death

Month Day Year
NOVEMBER 2 1996

3. Time of Death

3:57 PM

4e. Facility Name (If not institution, give street and number)

7511 CITADEL DRIVE

4b. City, Town, or Location of Death

COLLEGE PARK

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

212-54-3799

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 5, 1930

9. Birthplace (State or Foreign Country)

South Africa

Usual Residence of Decedent

10e. State 10b. County 10c. City, Town or Location
Maryland Prince George's College Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7511 Citadel Drive

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisory Biologist

16b. Kind of Business/Industry

Agency
Enviromental Protection

17. Father's Name (First, Middle, Last)

Ellis Lydgate Pestell Thomas

18. Mother's Name (First, Middle, Maiden Surname)

May Ramsay

19e. Informant's Name/Relationship (Type, Print)

Dorothy Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7511 Citadel Drive, College Park, Maryland 20740

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

11/7/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Henry J. Ford

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, Md 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William J. Ford

29c. License number

DEPUTY MEDICAL EXAMINER
D 33954

29d. Date signed (Month, Day, Year)

NOVEMBER 3, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARIO F. GOLUE JR., M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34900

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED

THOMAS

2. Date of Death

Month Day Year
October 30, 1996

3. Time of Death

10:55 P.M.

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-88-5307

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 11, 1927

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

10b. County

District of Columbia

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3076 Stanton Road, S. E.

10f. Zip Code

20020

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Esther Davis

19a. Informant's Name/Relationship (Type, Print)

Vivian Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3076 Stanton Road, S.E., Washington, D. C. 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial Park

Date

11/7/96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D. C.

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardio Pulmonary arrest

New.

Due to (or as a consequence of):

b. Cancer of Stomach with Metastasis

1 year

Due to (or as a consequence of):

c. upper gastro intestinal bleeding

Due to (or as a consequence of):

d. mal nutrition

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Co PP

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. D. ...

29c. License number

025640

29d. Date signed (Month, Day, Year)

11-7-96

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Khosrow JAVACHI 1328 Southern Ave SE Washington Dc 20032

31. Data filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

John ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 34901**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alma CREIGHTON TESTERMAN

2. Date of Death

Month Day Year
October 28 1996

3. Time of Death

844 AM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston MD

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

220-01-0221

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 4, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1220 Emmorton Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Licensed Practical Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Rutherford Eugene Creighton

18. Mother's Name (First, Middle, Maiden Surname)

Esther Barrett Wroten

19a. Informant's Name/Relationship (Type, Print)

Judy Rinehart, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

126 Wheaton Lane, Churchville, Maryland 21028

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

11/1/96

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Robert K. McComas

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 min.

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hairy Cell LEUKEMIA

Due to (or as a consequence of):

5 yr.

c. High Blood Pressure

Due to (or as a consequence of):

10 yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert K. Dooley, MD

29c. License number

050782

29d. Date signed (Month, Day, Year)

October 31, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert Dooley 8530 PLEASANT PLAINS 21286

31. Date filed (Month, Day, Year)

NOV 8 1996

32. Registrar's Signature

Robert K. Dooley

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34902

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|-------------------------------|---|---|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WAYNE FULTON TODD | | | 2. Date of Death
Month Day Year
Nov. 8 1996 | | 3. Time of Death
3:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
401 Willis St. | | | 4b. City, Town, or Location of Death
Cambridge | | 4c. County of Death
Dorchester | |
| Funeral
Director | 5. Social Security Number
213-44-2286 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
51 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 16, 1945 |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Dorchester | | 10c. City, Town or Location
Cambridge |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
401 Willis St. | | 10f. Zip Code
21613 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) 5 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Forklift Operator | | 16b. Kind of Business/Industry
Food Processing | | |
| | 17. Father's Name (First, Middle, Last)
Willie T. Todd | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ada R. Ruark | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Carolyn H. Gates Sister | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4909 Harrison Ferry Road Hurlock, Maryland 21643 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Unity-Washington Cemetery | | Date
11/12/96 | | 20c. Location - City or Town, State
Hurlock, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Thomas Funeral Home, P.A.
700 Locust Street Cambridge, Maryland 21613 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Squamous cell carcinoma of left lung
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| State Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
0-28209 | | 29d. Date signed (Month, Day, Year)
Nov 8, 1996 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edmund J. MacLaughlin 4 Aurora St Cambridge, Md 21613 | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 12 1996 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #17, *all*
Allegany Co. 11-12-96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34903

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
EARL WILLIAM TROUTMAN | | 2. Date of Death
Month October Day 28 Year 1996 | | 3. Time of Death
12:25am | |
| 4a. Facility Name (If not institution, give street and number)
Memorial Hospital & Medical Center | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| 5. Social Security Number
213-12-9679 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
Jan. 3, 1922 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| 10a. State
Maryland | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
Route 8, Box 349 | | 10f. Zip Code
21502 | |
| 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: W.W.II | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self-employed | | 16b. Kind of Business/Industry
Trucking | | 17. Father's Name (First, Middle, Last)
Frank Troutman | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Emma Porter | | 19a. Informant's Name/Relationship (Type, Print)
David Troutman | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
310 Jefferson Street - Cumberland, MD 2102 | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Davis Memorial Cemetery | | 20c. Location - City or Town, State
10/30/96 Cumberland, MD | |
| 21. Signature of Funeral Service Licensee
<i>Steady D. Upchurch</i> | | 22. Name and Address of Facility
George-Upchurch Funeral Home, P.A.
202 Greene St., Cumberland, MD 21502 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Ventricular Fibrillation
Due to (or as a consequence of):

b. Coronary Heart Disease
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year)
Nov 12 1996 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> M.D. | | 29c. License number
D 23334 | |
| 29d. Date signed (Month, Day, Year)
Oct- 31 1996 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Dinesh Shah-Johnson Heights Medical Building-Cumberland, MD 21502 | | 31. Date filed (Month, Day, Year)
NOV 12 1996 | |
| 32. Registrar's Signature
<i>[Signature]</i> | | 33. Registrar's Title
State Registrar | | 34. Registrar's Office
State Registrar | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34904

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN TABLER

2. Date of Death

Month
NOV.Day
8Year
19963. Time of Death
6:55 A.M.

4a. Facility Name (If not institution, give street and number)

FROSTBURG VILLAGE NURSING HOME

4b. City, Town, or Location of Death

FROSTBURG

4c. County of Death

ALLEGANY

5. Social Security Number

217-10-1626

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 25, 1918

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

West Va

10b. County

Mineral

10c. City, Town or Location

Ridgeley

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Poplar Street

10f. Zip Code

26753

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laundry Worker

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Allen McCort

18. Mother's Name (First, Middle, Maiden Surname)

Lena Alice Kalor

19a. Informant's Name/Relationship (Type, Print)

Richard M. Tabler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 262 - Ridgeley, WV 26753

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Restlawn Memorial Gardens 11/11/96 LaVale, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Shirley N. Upchurch

22. Name and Address of Facility

George-Upchurch Funeral Home, P.A.
202 Greene St., Cumberland, MD 21502

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Cardiac failure*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 wks.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *arteriosclerosis*
Due to (or as a consequence of):

10 yrs.

c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shirley N. Upchurch

29c. License number

D12532

29d. Date signed (Month, Day, Year)

11/8/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George Brown, M.D. - 912 Seton Dr. - Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 12 1996

32. Registrar's Signature

*John A. Harrison*State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

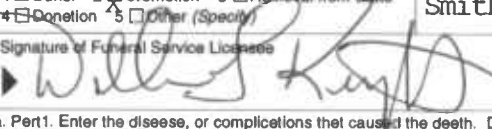
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

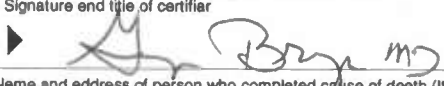
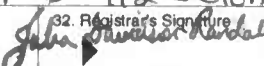
Certificate of Death

Reg. No.

96 34905

| | | | | | | | | | | |
|--|---|---|---|--|--|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ETHEL PEARL TROUTMAN | | | | 2. Date of Death
NOVEMBER 8, 1996 | | 3. Time of Death
12:15 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | | |
| Funeral
Director | 5. Social Security Number
217-48-1587 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 14, 1903 | | 9. Birthplace (State or Foreign Country)
WV | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
Maryland | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
315 Pearl Street | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
William Ferman McBride | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Etta Mae (Alderton) | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
Sarah S. Troutman | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11621 Apollo Ave., Cumberland, MD. 21502 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematorium | | Date
11/9/96 | | 20c. Location - City or Town, State
Smithsburg, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Kight Funeral Home
309-311 Decatur St., Cumberland, MD. 21502 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Stroke
Due to (or as a consequence of):
b. Arteriosclerosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
f.
g.
h.
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xr.
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xu.
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xw.
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xz.
ya.
yb.
yc.
yd.
ye.
yf.
yg.
yh.
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yj.
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yl.
ym.
yn.
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yp.
yq.
yr.
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yt.
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yv.
yw.
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yz.
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zc.
zd.
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zf.
zg.
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zi.
zj.
zk.
zl.
zm.
zn.
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zp.
zq.
zr.
zs.
zt.
zu.
zv.
zw.
zx.
zy.
zz. | | | | | | | | Approximate Interval Between Onset and Death
1 day
20 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Duchenne
Fracture left humerus
asthma | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D12532 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 12, 1996 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Breza M.D. 912 Seton Drive Cumberland, MD 21502 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 12 1996 | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34906

| | | | | | | | | |
|--|--|---|--|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KATHERINE ELIZABETH TWIGG | | | | 2. Date of Death
Month Day Year
NOVEMBER 5 1996 | | 3. Time of Death
3:30PM | |
| | 4a. Facility Name (If not institution, give street and number)
CUMBERLAND NURSING HOME | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
217-10-4102 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
MARCH 21 1912 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ALLEGANY | | 10c. City, Town or Location
LAVALLE | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
11017 ARIZONA AVE. N.W. | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CELANESE CORP. OF AMERICA | | 16b. Kind of Business/Industry
SILK/MANUF. | | |
| 17. Father's Name (First, Middle, Last)
CHARLES E. FISHER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
CATHERINE F. ZAPP | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
FRANCIS T. TWIGG HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11017 ARIZONA AVE. N.W. LAVALLE, MARYLAND 21502 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SUNSET CEMETERY | | Date
NOVEMBER 8, 1996 | | 20c. Location - City or Town, State
CUMBERLAND MARYLAND | | |
| 21. Signature of Funeral Service Licensee
<i>Dale L. Merritt</i> | | | | 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME
404 DECATUR STREET CUMBERLAND MARYLAND | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest
Due to (or as a consequence of):
b. Cardiomyopathy
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
3 minutes
12 m. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal failure | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dale L. Merritt MD.</i> | | | | 29c. License number
DO 4981 | | 29d. Date signed (Month, Day, Year)
Nov. 5. 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
PETER HALMOS 302 Schley st. Cumberland, Md. 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 06 1996 | | | | 32. Registrar's Signature
<i>John Davidson Randall</i> | | | | |

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34907

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

My Trinh

2. Date of Death

November 3, 1996

3. Time of Death

1:30 AM

4a. Facility Name (If not institution, give street and number)

11012 Cross Laurel Drive

4b. City, Town, or Location of Death

Germantown

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

217-94-0771

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 1, 1922

9. Birthplace (State or Foreign Country)

Vietnam

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11012 Cross Laurel Drive

10f. Zip Code

20876

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Chi Trinh

18. Mother's Name (First, Middle, Maiden Surname)

Thi Dao

19a. Informant's Name/Relationship (Type, Print)

Minh H. Hong/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20409 Bloomingville Court, Germantown, MD 20876

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Nov. 5, 1996

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Ray Fank

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7-8 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Susan Withrow

29c. License number

D 20523

29d. Date signed (Month, Day, Year)

November 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Withrow, M.D. 12851 Wisteria Drive, Germantown, Maryland 20874

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34908

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Owen T. Thornberry, Jr. | | | | 2. Date of Death
Month October Day 31 , Year 1996 | | 3. Time of Death
2:45P. | |
| | 4a. Facility Name (If not institution, give street and number)
4212 Howard Road | | | | 4b. City, Town, or Location of Death
Beltsville | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
467-56-0859 | | 6. Sex
XX M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
58 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 21, 1938 | |
| | 9. Birthplace (State or Foreign Country)
Texas | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Beltsville | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4212 Howard Road | | 10f. Zip Code
20705 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Statistician | | 16b. Kind of Business/Industry
National Center for Health Statistics | | | |
| | 17. Father's Name (First, Middle, Last)
Owen Thornberry, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Leona Wiggins | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Jutta Thornberry (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as #10 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Data
11/1/1996 | | 20c. Location - City or Town, State
Alexandria, Virginia | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland 20705 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Carcinomatosis
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Prostate Cancer
Crohn's Disease | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State
Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D22123 | | 29d. Date signed (Month, Day, Year)
November 1, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark D. Goldman, M.D. 6525 Belcrest Road Hyattsville, Maryland 20782 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 04 1996 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34909

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Smith Taylor

2. Date of Death

Month

Day

Year

October

31

1996

3. Time of Death

0700

4e. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

215-48-2572

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Feb. 24, 1913

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

20 Grandin Circle

10f. Zip Code

20851-1338

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert Edward Smith

18. Mother's Name (First, Middle, Maiden Surname)

Ida Bell Currier

19e. Informant's Name/Relationship (Type, Print)

Harry E. Taylor/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Grandin Circle, Rockville, Maryland 20851-1338

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Evergreen Cemetery

Date

Nov. 5, 1996

20c. Location - City or Town, State

Moosup, Connecticut

21. Signature of Funeral Service Licensee

Raymond

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.

300 West Montgomery Avenue

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. lobar pneumonia

Due to (or as a consequence of):

10 days

c. small cell lung carcinoma

Due to (or as a consequence of):

~ 1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

gastrointestinal bleed

panniculitis

pancreatitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George A. Sidor

29c. License number

D43083

29d. Date signed (Month, Day, Year)

October 31, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

9707 MEDICAL CENTER DRIVE, #300 ROCKVILLE, MD 20850

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34910

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Diec Thi Vu

2. Date of Death

Month October Day 29, 1996

3. Time of Death

5:11 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1104 Kathryn Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

218-23-3706

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month May Day 18, Year 1919

9. Birthplace (State or Foreign Country)

Vietnam

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1104 Kathryn Road

10f. Zip Code

20904

10g. Citizen of What Country?

Vietnam

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Vietnamese

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Uan Vu

18. Mother's Name (First, Middle, Maiden Surname)

Phuc Le

19a. Informant's Name/Relationship (Type, Print)

Nam Pham / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1104 Kathryn Road, Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery 11/2/96 Silver Spring, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

L. L. Holland

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 2090423a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Tamber

29c. License number

DO 0546

29d. Date signed (Month, Day, Year)

October 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tamber 8218 Wisconsin Ave Bethesda MD

State
Registrar

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

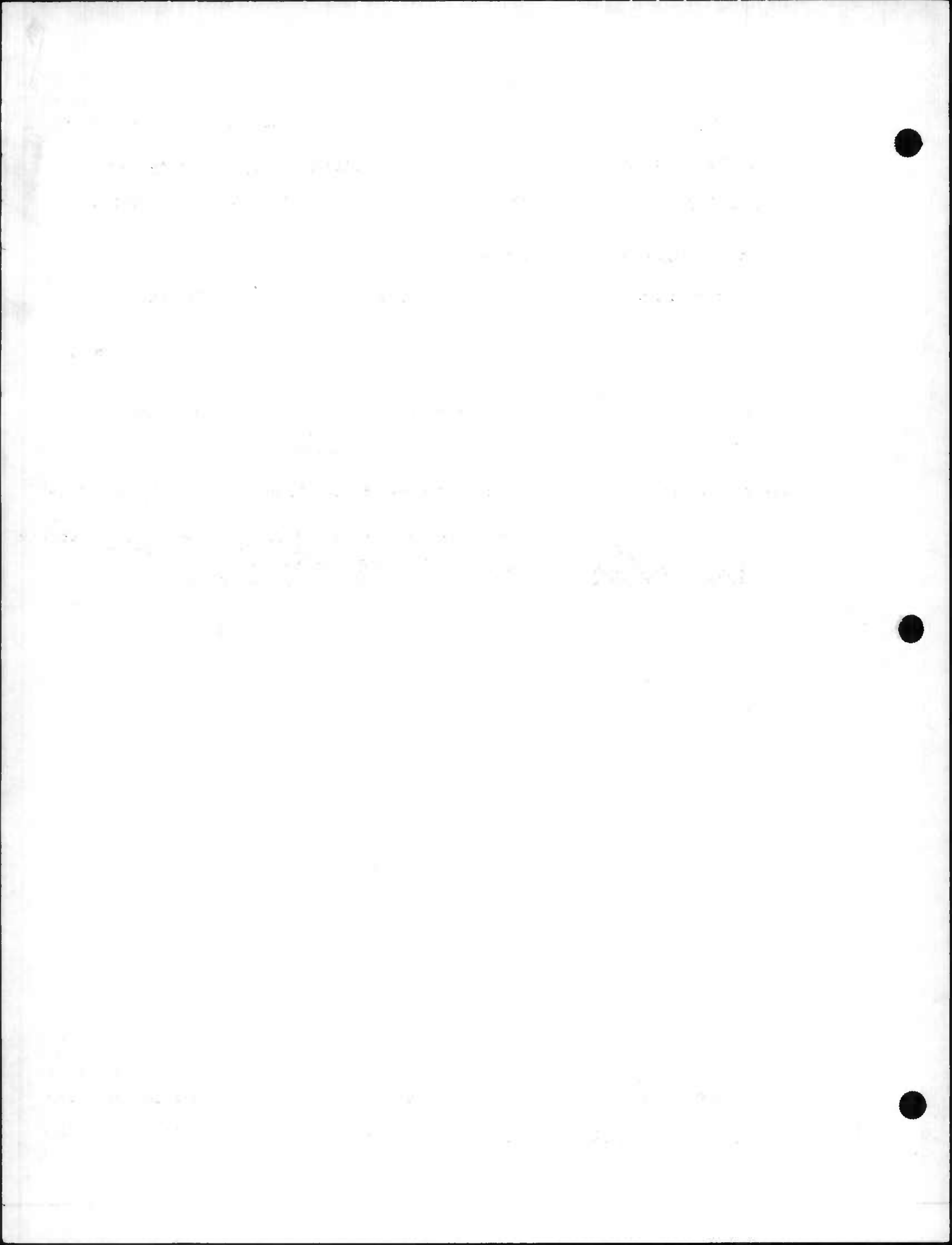
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34911

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>R.W. Jack Voigt</i> | | | | 2. Date of Death
Month <i>November</i> Day <i>3</i> Year <i>1996</i> | | 3. Time of Death
<i>9:09 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Montgomery General Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Olney</i> | | 4c. County of Death
<i>Montgomery</i> | |
| Funeral
Director | 5. Social Security Number
<i>577-40-5520</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>65</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Feb. 28, 1931</i> | 9. Birthplace (State or Foreign Country)
<i>Virginia</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
<i>Maryland</i> | | 10b. County
<i>Prince Georges</i> | | 10c. City, Town or Location
<i>Adelphi</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
<i>10111 Green Forest Drive</i> | | | | 10f. Zip Code
<i>20783</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Self-employed</i> | | 16b. Kind of Business/Industry
<i>Plumber</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Raphael L. Voigt</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Garline Sullivan</i> | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Elaine J. Waugh / Friend</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>10111 Green Forest Drive, Adelphi, Maryland 20783</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Wilderness Bapt. Ch. Cem.</i> | | Date
<i>11/6/96</i> | | 20c. Location - City or Town, State
<i>Spotsylvania, VA</i> | |
| | 21. Signature of Funeral Service Licensee
<i>Thomas Guyon</i> | | | | 22. Name and Address of Facility
<i>Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Metastatic Small Cell Cancer</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
<i>b. Due to (or as a consequence of):</i>
<i>c. Due to (or as a consequence of):</i>
<i>d. Due to (or as a consequence of):</i> | | | | | | | Approximate Interval Between Onset and Death
<i>One month</i> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>033686</i> | | 29d. Date signed (Month, Day, Year)
<i>November 3, 1996</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Kathleen M. Williams, 18111 Pine Philip Dr. Chevy Chase, MD 20832</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>NOV 07 1996</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

65

State
Registrar

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) PHYLLIS COVE WILSON
2. Date of Death Month Day Year NOV. 4 1996
3. Time of Death 1:22 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number) 7764 BLOOMFIELD ROAD
4b. City, Town, or Location of Death EASTON
4c. County of Death TALBOT
5. Social Security Number 032-26-7827
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 64 Yrs.
8. Date of Birth (Month, Day, Year) AUG. 17, 1932
9. Birthplace (State or Foreign Country) MASS.

To Be Completed by Funeral Director

Usual Residence of Decedent
10a. State MD
10b. County TALBOT
10c. City, Town or Location EASTON
10d. Inside City Limits 1 ☐ Yes 2 ☒ No
10e. Street and Number 7764 BLOOMFIELD ROAD
10f. Zip Code 21601
10g. Citizen of What Country? USA
11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 +
16. Kind of Business/Industry OWN HOME
17. Father's Name (First, Middle, Last) CHARLES T. COVE
18. Mother's Name (First, Middle, Maiden Surname) MALVINA DAVIS
19a. Informant's Name/Relationship (Type, Print) PAUL C. WILSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7764 BLOOMFIELD ROAD, EASTON, MD 21601
20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER, L.L.C.
20c. Location - City or Town, State 11-5 CHESTER, MD
21. Signature of Funeral Service Licensee
22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. Hypercalcemia Due to (or as a consequence of) b. Nonsmall cell lung cancer, 1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): 1 month.
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Head + neck cancer.

23b. Did tobacco use contribute to the cause of death?
1 ☒ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)
27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number D39887
29d. Date signed (Month, Day, Year) 11/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID H. SMITH, M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601

State
Registrar

31. Date filed (Month, Day, Year) NOV - 6 1996
32. Registrar's Signature

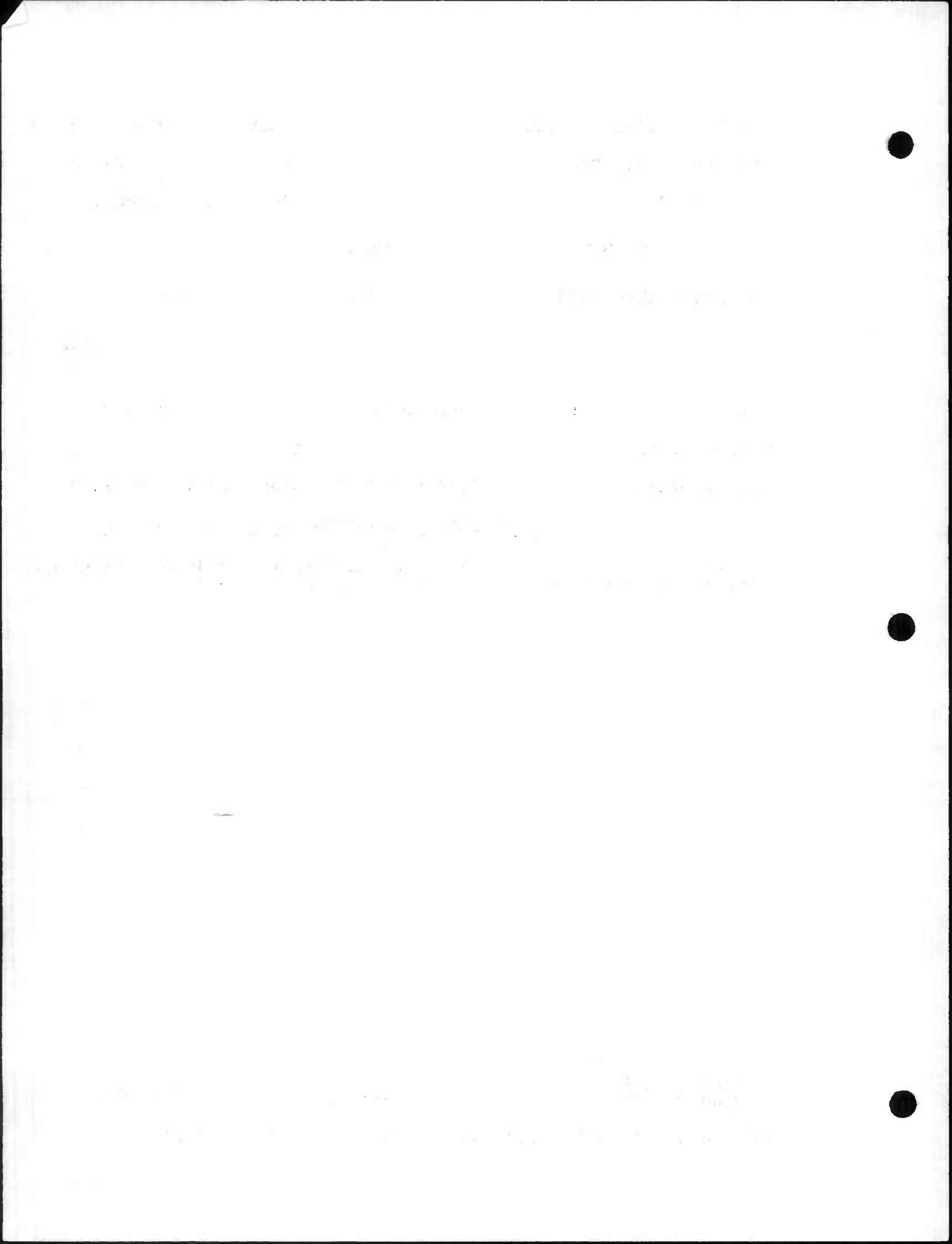
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34913

Certificate of Death

Reg. No.

2 1/1

| | | | | | | | | |
|---|---|---------------------------------------|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carlos M. Wines | | | | 2. Date of Death
Month November Day 1 Year 1996 | | 3. Time of Death
7:10AM | |
| | 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
216-06-6237 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
26 Yrs. | If Under 1 Year
Months 0 Days 0 | If Under 24 Hrs
Hours 0 Min. 0 | 8. Date of Birth (Month, Day, Year)
JULY 25, 1970 | |
| | 9. Birthplace (State or Foreign Country)
ARLINGTON, VA | | | | | | | |
| 10a. State
MD | | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
CLINTON | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
8602 TEMPLE HILLS ROAD | | | | 10f. Zip Code
20735 | | 10g. Citizen of What Country?
UNITED STATES | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
STUDENT | | 18b. Kind of Business/Industry
EDUCATIONAL | | |
| 17. Father's Name (First, Middle, Last)
PERCY WINES | | | | 18. Mother's Name (First, Middle, Maiden Surname)
GLORIA REID | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
GLORIA WINES - MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8602 TEMPLE HILLS RD. CLINTON, MD 20735 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ROCKHILL CEMETERY | | Date
11/6/96 | | 20c. Location - City or Town, State
BLUEMONT, VA | |
| 21. Signature of Funeral Service Licensee
Alex S. Pope Jr. | | | | 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOMES
5538 MARLBORO PIKE FORESTVILLE, MD 20747 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Hepato renal syndrome
Due to (or as a consequence of):
Acquired Immunodeficiency Syndrome
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
6 days | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
[Signature] | | | | |
| | | | | 29c. License number
D46478 | | 29d. Date signed (Month, Day, Year)
11-2-96 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Suresh A. Patel MD 7501 Surratt Rd # 302 Clinton md 20735 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 05 1996 | | | | 32. Registrar's Signature
[Signature] | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2

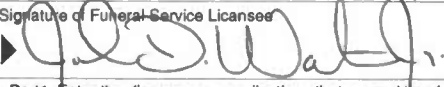
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


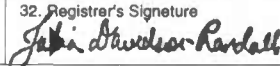
96 34914

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|--|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THELMA S. WYATT | | | | 2. Date of Death
Month Day Year
NOV. 5 1996 | | | | 3. Time of Death
12:30PM | |
| | 4a. Facility Name (If not Institution, give street and number)
MARINER HEALTH | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
230 12 6151 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG 20 1920 | | 9. Birthplace (State or Foreign Country)
WASH. D. C. | |
| | Usual Residence of Decedent | | | | 10a. State
VA. | | 10b. County
CHESTERFIELD | | 10c. City, Town or Location
ETTRICK | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
20403 WILLIAMS ST. | | | | 10f. Zip Code
23803 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 6 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TEACHER | | | | 16b. Kind of Business/Industry
SCHOOL SYSTEM | | | | 17. Father's Name (First, Middle, Last)
RAWLINS SHEPPERSON | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
HESTER KEELING | | | | 19a. Informant's Name/Relationship (Type, Print)
EDWARD WYATT | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8108 CEDARGATE PL., GLENN DALE MD. 20769 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
DINWIDDIE MEM. CEM. 11/8/96 | | | | 20c. Location - City or Town, State
DINWIDDIE, VA. | |
| | 21. Signature of Funeral Service Licenses
 | | | | 22. Name and Address of Facility
WATSON F. H. INC.
3435 14th ST., N.W. 20010 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. NON-HODGKINS LYMPHOMA
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. c. d. | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D01120 | | | | 29d. Date signed (Month, Day, Year)
NOV 7, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WALTER E. GOOZH M.D. 2309 SHOREFIELD RD. WHEATON, MD. 20902 | | | | 31. Date filed (Month, Day, Year)
NOV 08 1996 | | | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34915

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Abraham Wren | | 2. Date of Death
Month November Day 4 Year 1996 | | 3. Time of Death
6:50 pm | |
| 4e. Facility Name (If not institution, give street and number)
Laurel Regions' Hospital | | 4b. City, Town, or Location of Death
Laurel | | 4c. County of Death
Prince George's | |
| 5. Social Security Number
577-62-1850 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
49 Yrs. | If Under 1 Year
Months 4 Days 19 | If Under 24 Hrs.
Hours 19 Min. 50 | 8. Date of Birth (Month, Day, Year)
SEP 25, 1947 |
| 9. Birthplace (State or Foreign Country)
Wash., D.C. | | | | | |
| Usual Residence of Decedent | | | | | |
| 10e. State
Maryland | 10b. County
Prince Georges | 10c. City, Town or Location
Temple Hills | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
2609 Buckner Lane | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) College | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Offset Pressman | | 16b. Kind of Business/Industry
Private | |
| 17. Father's Name (First, Middle, Last)
Abraham Wren, II | | 18. Mother's Name (First, Middle, Maiden Surname)
Evelyn Golds | | | |
| 19e. Informant's Name/Relationship (Type, Print)
Charlene V. Wren (wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2609 Buckner Lane, Temple Hills, Md. 20748 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Location - City or Town, State
11/12/96 Landover, Maryland | |
| 21. Signature of Funeral Service Licensee
Alex S. Pope | | 22. Name and Address of Facility
M859 ALEXANDER S. POPE FUNERAL HOMES
5538 Marlboro Pike, Forestville, Md. 20747 | | | |
| 23a. Pert. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Gangrenous fingers, Infected graft
Due to (or as a consequence of):
c. Decubitus Ulcer
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Endstage Renal Disease
Diabetes Mellitus | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Jenny Y. Moy, MD | | 29c. License number
D43260 | | 29d. Date signed (Month, Day, Year)
November 5th 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jenny Y. Moy, MD 14333 Laurel Boulevard #307 Laurel MD 20708 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 08 1996 | | 32. Registrar's Signature
John Andrew Randall | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

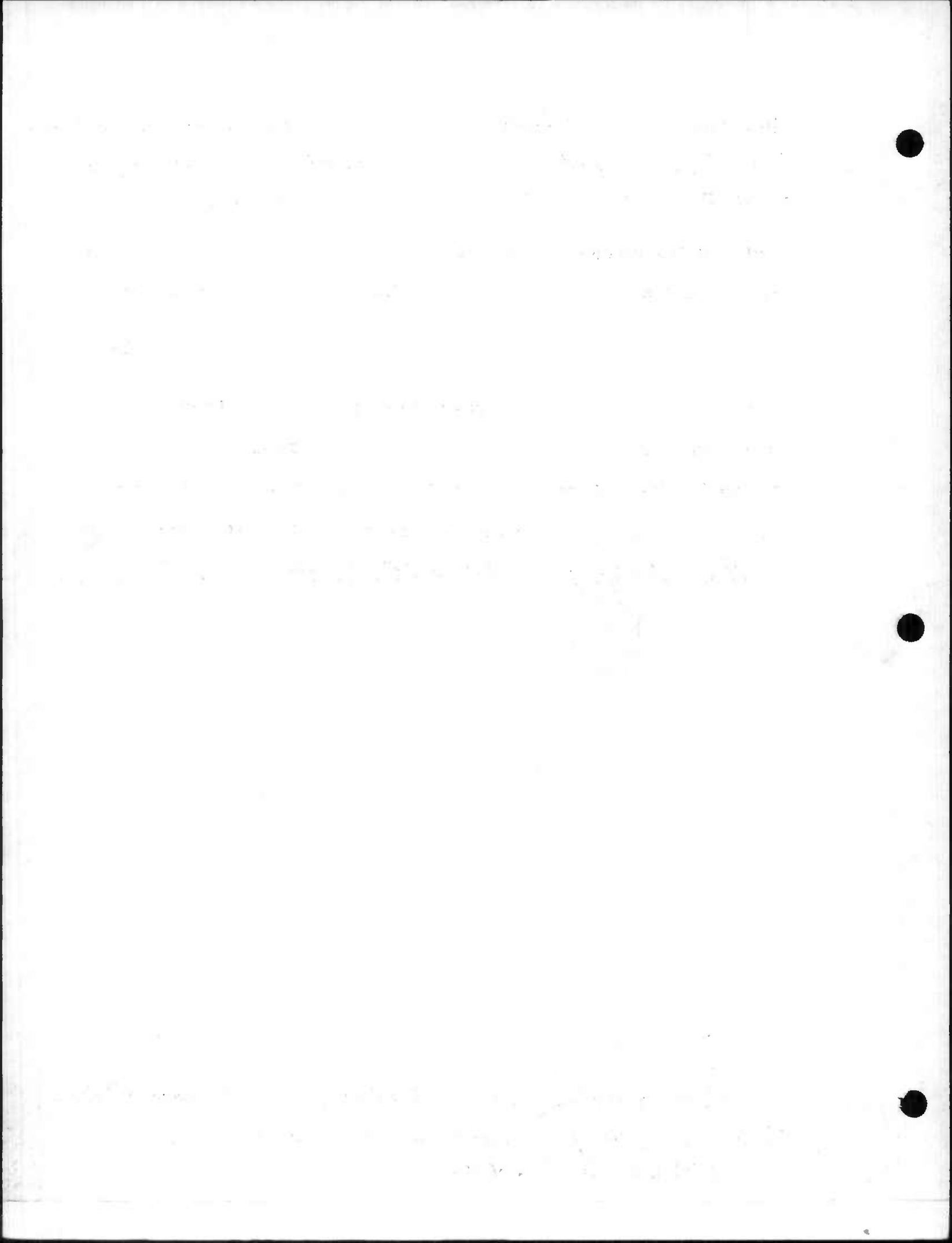
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

7

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34916

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Williams

2. Date of Death

Month

Day

Year

Nov 1, 1996

3. Time of Death

7:16 PM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

117-32-0705

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 31, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Va.

10b. County

Ablemarle

10c. City, Town or Location

Charlottesville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

709 Anderson Street

10f. Zip Code

22903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Issac Kennedy

18. Mother's Name (First, Middle, Maiden Surname)

Eliza Jefferson

19a. Informant's Name/Relationship (Type, Print)

Charles T. Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

709 Anderson St., Charlottesville, Va., 22903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cem. 11/08/96

Date

20c. Location - City or Town, State

Charlottesville, Va.

21. Signature of Funeral Service Licensee

W. J. Jefferson

22. Name and Address of Facility

Frazier Funeral Home, Inc.

389 Rhode Island Ave., NW, Washington, D.C. 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Respiratory Failure

Due to (or as a consequence of):

Chronic Obstructive Pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 Day

Many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. S. Saluja

29c. License number

D17537

29d. Date signed (Month, Day, Year)

11-2-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHAN S. SALUJA 1600 W-MOUNT Royal Ave, Balto MD 21217

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-695-0026.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34917

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Madeleine W. Williams

2. Date of Death

November 2, 1996

3. Time of Death

11:59 P.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-56-6649

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 18, 1942

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

39 Loughton St.

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive Secretary

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Elliotte J. Williams

18. Mother's Name (First, Middle, Maiden Surname)

Jayne Maynard

19a. Informant's Name/Relationship (Type, Print)

Michael M. Williams/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7505 Greer Dr., Fort Washington, Md. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

11/8/96

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Maryland 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D-33954

29d. Date signed (Month, Day, Year)

NOVEMBER 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mario F. Golle, Jr. M.D. 3001 Hospital Drive, Cheverly, Md. 20785

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34918

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **CALIP JOHN WHITE** 2. Date of Death Month **October** Day **29** Year **1996** 3. Time of Death **5:53PM**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **Veterans Administration Hospital Baltimore Baltimore, Maryland** 4b. City, Town, or Location of Death **Baltimore, Maryland** 4c. County of Death

5. Social Security Number **236-46-3758** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **64** Yrs. 8. Date of Birth (Month, Day, Year) **Dec. 31, 1931** 9. Birthplace (State or Foreign Country) **Virginia**

Usual Residence of Decedent

10a. State **Maryland** 10b. County **Harford** 10c. City, Town or Location **Bel Air** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **9 South Atwood Road** 10f. Zip Code **21014** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates: **1951-55** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **white**

15. Decedent's Education (Specify only highest grade completed) **11** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Foreman** 16b. Kind of Business/Industry **Shoe Manufacturing**

17. Father's Name (First, Middle, Last) **Robert Monroe White** 18. Mother's Name (First, Middle, Maiden Surname) **Mary Rebecca Mitchell**

19a. Informant's Name/Relationship (Type, Print) **Gertrud White, Wife** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **3803 Longley Road, Abingdon, Maryland 21009**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Holly Hill Memorial Gardens** Date **11/1/96** 20c. Location - City or Town, State **Middle River, Md.**

21. Signature of Funeral Service Licensee **Howard K. McComas III** 22. Name and Address of Facility **Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) **a. Asystole** Due to (or as a consequence of): **1 minute**
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last **b. congestive heart failure** Due to (or as a consequence of): **many years**
c. ischemic cardiomyopathy Due to (or as a consequence of): **many years**
d. chronic renal failure Due to (or as a consequence of): **several years**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **N. Christine Le** 29c. License number **PO 8673** 29d. Date signed (Month, Day, Year) **October 29, 1996**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **N. Christine Le 10. North Greene St. Baltimore, MD 21201**

31. Date filed (Month, Day, Year) **NOV 1 1996** 32. Registrar's Signature **John Davidson-Randall**

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34919
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD JOHN WEAVER

2. Date of Death

Month Day Year
NOVEMBER 5, 1996

3. Time of Death

1315 PM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

181-03-8137

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
Aug 13, 1910

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Taylor Street

10f. Zip Code

21532

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Manager

16b. Kind of Business/Industry

Kline Furniture Store

17. Father's Name (First, Middle, Last)

Paul Weaver

18. Mother's Name (First, Middle, Maiden Surname)

Helen (Deitrich)

19a. Informant's Name/Relationship (Type, Print)

Julia Weaver--wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Taylor Street; Frostburg, MD 21532

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

11/06

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CA OF THE (R) LUNG, METASTASIS

Due to (or as a consequence of):

b. TO BILATERAL PLEURA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chang H. H. MD

29c. License number

D24951

29d. Date signed (Month, Day, Year)

NOVEMBER 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANG H. H. MD, 48 STAR TERRACE, FROSTBURG, MD 21532

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson Hardall

State
Registrar

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34920

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|---|--|--|--|---|---|-----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BERNICE ALFREDA WOTRING | | | | 2. Date of Death
Month Day Year
OCTOBER 30 1996 | | 3. Time of Death
5:17 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL & MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | | |
| Funeral
Director | 5. Social Security Number
220-10-4985 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
Mar 21, 1915 | | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cresaptown | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
Grant 14905 Grand Street | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired Employee | | 16b. Kind of Business/Industry
Allegany Ballistics Lab | | | | |
| | 17. Father's Name (First, Middle, Last)
Marshal Sanders | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude (Ashby) | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Roger F. Wotring--husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 5211; Cresaptown, MD 21502 | | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Park | | 20c. Location - City or Town, State
11/02 Cumberland, MD | | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Metastatic Carcinoma of the Colon
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death
2 Weeks
3 Years | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| To Be Completed by Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
 | | | | 29c. License number
D 17246 | | 29d. Date signed (Month, Day, Year)
10/31/96 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RICHARD SNIDER M.D., MEMORIAL HOSPITAL SUITE 402, CUMBERLAND, MD 21502 | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | | | | | | | |
| | 32. Registrar's Signature
 | | | | | | | | |

asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34921

| | | | | | | |
|---|---|--|---|--------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FON WONG | | 2. Date of Death
Month Day Year
Oct 31 1996 | | 3. Time of Death
9:30 P | |
| | 4a. Facility Name (If not institution, give street and number)
ASPIN HILL RD. & GEORGIA AVE | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
213-98-2283 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 7, 1909 |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
China | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Montgomery | 10c. City, Town or Location
Olney | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
4317 Skymist Terrace | | 10f. Zip Code
20832 | | 10g. Citizen of What Country?
China | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: Asian | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Security Officer | |
| | 16b. Kind of Business/Industry
Security | | 17. Father's Name (First, Middle, Last)
Man Cheong Wong | | 18. Mother's Name (First, Middle, Maiden Surname)
Chang Oi Lau | |
| | 19a. Informant's Name/Relationship (Type, Print)
Kam Wong | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4317 Skymist Terrace, Olney, Maryland 20832 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Norbeck Memorial Park | | 20c. Location - City or Town, State
11/4/96 Olney, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd. W. Silver Spring, MD 20901 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. <u>Multiple Injuries</u>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
10-31-96 | | 28b. Time of Injury
930 P M | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
pedestrian struck by car | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
Mont. Co Georgia Ave & Aspen Hill Rd | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | |
| State Registrar | 29d. Date signed (Month, Day, Year)
NOVEMBER 01, 1996 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | |
| | 31. Date filed (Month, Day, Year)
NOV 06 1996 | | 32. Registrar's Signature
 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34922

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH

WILLIS

2. Date of Death

Month Day Year
OCT. 27, 1996

3. Time of Death

2:15 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

CARRIAGE HILL NURSING CENTER

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

236-26-1803

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 27, 1914

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

CHEVY CHASE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8100 CONNECTICUT AVE.

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

PARREN STUMP

18. Mother's Name (First, Middle, Maiden Surname)

GEORGIE LOUISE SEAGLE

19a. Informant's Name/Relationship (Type, Print)

EDWARD H. WILLIS, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7409 FAIRFAX ROAD, BETHESDA, MD. 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. COMFORT CREMATORY

Data

11/2

20c. Location - City or Town, State

ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH GAWLER'S SONS, 5130 WISCONSIN AVE., N.W.
WASHINGTON, DC. 20016

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ADENOCARCINOMA, RIGHT LUNG

Approximate Interval Between Onset and Death

6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SENILE DEMINTIA (MULTIFARCT)

URINARY INFECTION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DO 7471

29d. Date signed (Month, Day, Year)

OCT. 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. PAUL NOONE 50 WEST EDMONSTON DR. # 207 ROCKVILLE, MD. 20852

31. Date filed (Month, Day, Year)

NOV 07 1996

32. Registrar's Signature

Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34924

| | | | | | | | | | | | |
|---|--|--------------------------------|--|---|---|---------------------------------|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BEULAH OLIVE YUTZY | | | | 2. Date of Death
Month NOVEMBER Day 1 , Year 1996 | | | | 3. Time of Death
1645 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | | | 4c. County of Death
ALLEGANY | | |
| Funeral
Director | 5. Social Security Number
220-07-6337 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT 20 1919 | | 9. Birthplace (State or Foreign Country)
PA. | | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
CUMBERLAND | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10e. State
MARYLAND | | 10b. County
ALLEGANY | | 10f. Zip Code
21502 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| 10e. Street and Number
1803 HOLLAND STREET | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 2 | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LEGAL SECRETARY | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 17. Father's Name (First, Middle, Last)
HARVEY M. MAY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HESTER A. HOLLER | | | | 16b. Kind of Business/Industry
SECRETARY | | | |
| 19e. Informant's Name/Relationship (Type, Print)
ROY W. YUTZY HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1803 HOLLAND STREET CUMBERLAND, MARYLAND 21502 | | | | | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MADLEY CEMETERY | | | | Date
NOVEMBER 4 1996 | | 20c. Location - City or Town, State
HYNDMAN, PA. | |
| 21. Signature of Funeral Service Licensee
<i>Dale L. Merritt</i> | | | | 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME
404 DECATUR STREET CUMBERLAND MARYLAND | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. ACUTE PNEUMONIA & RESPIRATORY FAILURE
Due to (or as a consequence of):</p> <p>b. CA. OF THE BREAST, METASTASIS TO
Due to (or as a consequence of):</p> <p>c. NECK BONES AND LUNGS
Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>15 DAYS</p> <p>15 YEARS</p> </div> </div> | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>Chang Oh M.D.</i> | | | | 29c. License number
D-24951 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 2, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. CHANG OH 48 TARN TERRACE FROSTBURG, MARYLAND 21532 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 04 1996 | | | | 32. Registrar's Signature
<i>Johanna Davidson Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96-4996-033

AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34925

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KI SUN YIM

2. Date of Death

Month Day Year
SEPT. 02, 1996

3. Time of Death

21:30 P

4a. Facility Name (If not institution, give street and number)

8301 ASHFORD BLVD. APT. 901

4b. City, Town, or Location of Death

Laurel

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

416-37-3133

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 10, 1957

9. Birthplace (State or Foreign Country)

Korea

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8301 Ashford Blvd., Apt. 901

10f. Zip Code

20707

10g. Citizen of What Country?

Korea

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Korean

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown Yoon

18. Mother's Name (First, Middle, Maiden Surname)

Unknown Kang

19a. Informant's Name/Relationship (Type, Print)

Ki Chae Yim / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8301 Ashford Blvd., Apt. 901, Laurel, Maryland 20707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Crematory

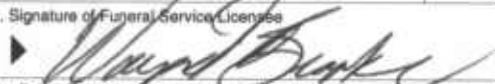
Date

9/6/96

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Gunshot Wound of Chest*
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?

INSPECTION

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
F 9-2-96

28b. Time of Injury

F 2:27 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

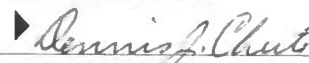
self-inflicted gunshot

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number,
City or Town, State)8301 Ashford Blvd Apt 901
Laurel, Md29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

OCME

29d. Date signed (Month, Day, Year)

SEPT. 04, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

SEP 05 1996

32. Registrar's Signature



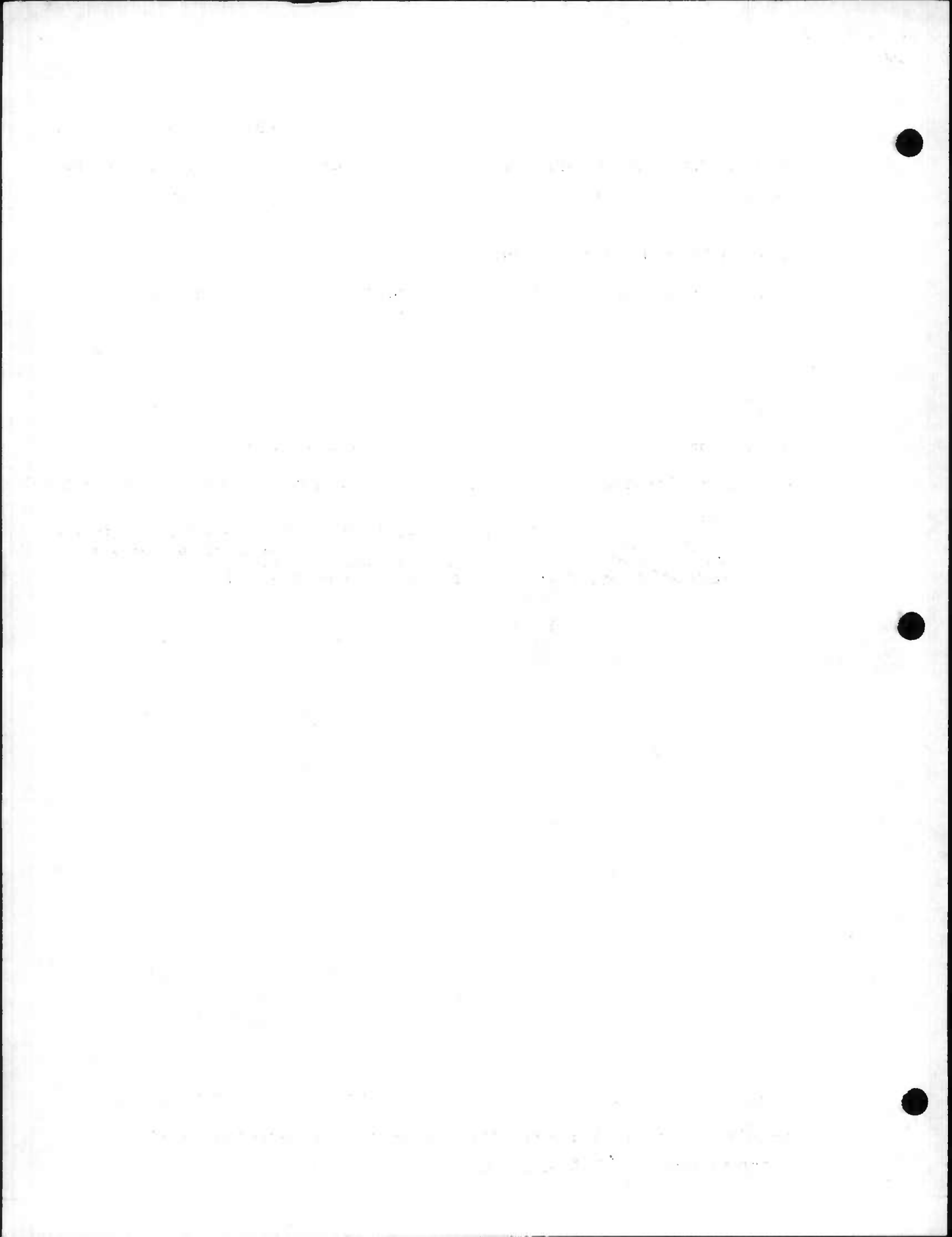
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34926

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT ELWOOD ZIMMERMAN | | | | 2. Date of Death
Month NOVEMBER Day 2 , Year 1996 | | 3. Time of Death
0230 am | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
217-18-4110 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 22, 1917 | |
| | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
517 Caroline Street | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) Collage | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired Engineer | | 16b. Kind of Business/Industry
Potomac Edison Co. | |
| | 17. Father's Name (First, Middle, Last)
Thomas A. Zimmerman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Effie (Kerns) | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mary M. Zimmerman--wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
517 Caroline Street; Cumberland, MD 21502 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Davis Memorial Cemetery | | 20c. Location - City or Town, State
11/05 Cumberland, MD | | 20d. Location - City or Town, State
Cumberland, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
James F. Scarpelli | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA OF THE LUNG
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. T y R
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | Approximate Interval Between Onset and Death
T y R | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28d. Describe how injury occurred | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier
Paul J. Livengood MD | |
| | 29c. License number
023774 | | | | | | 29d. Date signed (Month, Day, Year)
NOVEMBER 2, 1996 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL T. LIVENGOOD MD 912 SETON DRIVE CUMBERLAND MD 21502 | | | | | | 31. Date filed (Month, Day, Year)
NOV 04 1996 | |
| | 32. Registrar's Signature
John Davidson-Randall | | | | | | 33. Registrar's Signature | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene


Certificate of Death

96 34927

Reg. No.

| | | | | | | | | |
|-------------------------------------|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNA ZELTSE | | | | 2. Date of Death
Month Day Year
Oct. 11, 1996 | | 3. Time of Death
1:00AM | |
| | 4a. Facility Name (If not institution, give street and number)
1103 N. BELGRADE RD. | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
094 12 0120 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 12, 1912 | |
| | 9. Birthplace (State or Foreign Country)
POLAND | | 10a. State
MD. | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
SILVER SPRING | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
1103 N. BELGRADE RD. | | 10f. Zip Code
20902 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
2nd Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
Samuel Reisfeld | | 18. Mother's Name (First, Middle, Maiden Surname)
Ester Unknown | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Melvin Zeltser | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as item 10a-f | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Montefiore Cemetery | | Date
10/11 | | 20c. Location - City or Town, State
Parklawn, New York | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Ives Pearson Funeral Homes
472 N. Washington Street Falls Church, VA 22046 | | | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | e. Aspiration pneumonia
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | |
| | b. dementia - alzheimer's type
Due to (or as a consequence of): | | | | | | Years | |
| | c. diabetes mellitus
Due to (or as a consequence of): | | | | | | Years | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
017423 | | 29d. Date signed (Month, Day, Year)
10/11/96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RUTH COHEN, M.D. 8700 GEORGIA AVE., SUITE 44 SILVER SPRING, MD. 20910 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 04 1996 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34928

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bettie Ellis Zima

2. Date of Death

November 3, 1996

3. Time of Death

10:22 AM

4a. Facility Name (If not institution, give street and number)

5964 Searl Terrace

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-12-9666

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 18, 1921

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5964 Searl Terrace

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George J. Ellis

18. Mother's Name (First, Middle, Maiden Surname)

Margarete French Long

19a. Informant's Name/Relationship (Type, Print)

John A. Zima/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5441 Sand Flat Road, Harrison, Arkansas 72601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium or other place)

Montgomery Crematorium, Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Ray Paul M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

Bethesda-Chevy Chase, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiac Arrest

Approximate Interval Between Onset and Death

Immediate

Due to (or as a consequence of):

Metastatic Colon Cancer

1994

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George W. Graves M.D.

29c. License number

D29353

29d. Date signed (Month, Day, Year)

November 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George W. Graves, M.D., 5530 Wisconsin Avenue, Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

NOV 06 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

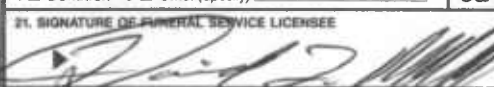
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

96 34929

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Helen Marie Zuraski | | | | 2. DATE OF DEATH
MONTH DAY YEAR
November 2, 1996 | | 3. TIME OF DEATH
11:00 A M | |
| 4. SOCIAL SECURITY NUMBER
577-28-5708 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
90 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
June 5, 1906 | | 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | |
| 9a. FACILITY NAME (If not institution, give street and number)
15115 Interlachen Drive, #508 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Silver Spring | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
15115 Interlachen Drive, #508 | | | | 10f. ZIP CODE
20906 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Auditor | | 16b. KIND OF BUSINESS/INDUSTRY
Civil Service | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank Zuraski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Helen Walewska | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joseph A. Zuraski / Brother | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1602 Parham Place, Silver Spring, Maryland 20903 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | 20c. LOCATION — City or Town, State
Silver Spring, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest Secondary to Atherosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {
a. Hypertension
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Aortic Aneurysm - Thoracic / Abdominal
Left Breast Cancer - Prior Mastectomy | | | | | | | Approximate Interval Between Onset and Death
1 Day
20 years |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
W. Ferri MD | | | | 29c. LICENSE NUMBER
D31918 | | 29d. DATE SIGNED (Month, Day, Year)
November 2, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
WARREN O. FERRIS MD, 3305 North Lescure World Boulevard, Silver Spring MD 20906 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 07 1996 | | 32. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34930

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rosa Maria Attadia de Zoccali

2. Date of Death

October 30, 1996

3. Time of Death

4:45 am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

078-32-3895

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 16, 1917

9. Birthplace (State or Foreign Country)

Argentina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8004 Kentbury Drive

10f. Zip Code

20814

10g. Citizen of What Country?

Argentina

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify:
Argentinean14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Bernardino Attadia

18. Mother's Name (First, Middle, Maiden Summa)

Rosario Avella

19a. Informant's Name/Relationship (Type, Print)

A. Guillermo Zoccali/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7505 New Market Drive Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of
cemetery, crematory or other place)November 1, 1996
Gate of Heaven Mausoleum

Data

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-350123a. Part I. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

13 DAYS

b.

BILATERAL PNEUMONIA

Due to (or as a consequence of):

13 DAYS

c.

MYOCARDIAL INFARCTION

Due to (or as a consequence of):

13 DAYS

d.

J E P S I I

13 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JAQUINS MD

29c. License number

D29256

29d. Date signed (Month, Day, Year)

OCTOBER 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSE A. QUIROS MD 4343 MONTGOMERY AV. BETHESDA MD 20814

31. Date filed (Month, Day, Year)

NOV 04 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34931

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SARAH ADLEMAN | | | | 2. Date of Death
Month Day Year
November 12, 1996 | | 3. Time of Death
4:45 PM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
220-12-6499 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
NOV. 28, 1910 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
3902 SETONHURST RD. | | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
OWN HOME | |
| 17. Father's Name (First, Middle, Last)
SOLOMON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
IDA FINE | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ROMA TAYLOR (DAUG.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3902 SETONHURST RD. BALTO., MD 21208 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OHIEL YAKOV-BETH ISRAEL | | Date
11/14/96 | | 20c. Location - City or Town, State
BALTIMORE, MD | | |
| 21. Signature of Funeral Service Licensee
<i>Michael Kruger</i> | | | | 22. Name and address of Facility
SOE LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA
ABDOMINAL AORTIC ANEURYSM | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury
(Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
g ginder P mehta. M.D | | | | | | |
| 29c. License number
D41410 | | 29d. Date signed (Month, Day, Year)
November 12, 1996 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital: Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34932

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

INEZ BOWERS

2. Date of Death

November 10, 1996

3. Time of Death

4:11 AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

n/a

5. Social Security Number

218-07-3224

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 12, 1918

9. Birthplace (State or Foreign Country)

DINWIDDIE VA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

900 N. PATTERSON PARK AVENUE

10f. Zip Code

21205

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

MEMORIAL STADIUM

17. Father's Name (First, Middle, Last)

JAMES THOMAS

18. Mother's Name (First, Middle, Maiden Surname)

DAISEY PEGRAM

19a. Informant's Name/Relationship (Type, Print)

GERTRUDE ALSTON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 N. PATTERSON PARK, BALTO., MD 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

11-13

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM. C. MARCH FH.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COMPLETE HEART BLOCK

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

22 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 10, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. MOORE, M.D., 600 N. WOLFE ST., BALTIMORE, MD, 21205

31. Date filed (Month, Day Year)

NOV 20 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

22

NOV 20 1969

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34933

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TIMOTHY BROWN JR.

2. Date of Death

Month 11 Day 18 Year 96

3. Time of Death

6:10 PM

4a. Facility Name (If not institution, give street and number)

BON SECOURS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

215-30-8205

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) SEPT. 20, 1934

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 N. MONROE STREET

10f. Zip Code

21223

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 9TH GRADE

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

CITY SANITATION DEPT.

17. Father's Name (First, Middle, Last)

TIMOTHY BROWN SR.

18. Mother's Name (First, Middle, Maiden Surname)

AMELIA WOODSON

19a. Informant's Name/Relationship (Type, Print)

AMELIA MATHIAS (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1505 ABBOTSTON ST, BALTIMORE, MD. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN STAR CEMETERY 11-25-96 CATONSVILLE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE., BALTO, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia, Staphylococcus aureus
Due to (or as a consequence of):
b. Infected Quinton catheter
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage Renal Disease
Pneumonia, left lower lobe

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D16263

29d. Date signed (Month, Day, Year)

Nov. 18, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JUAN A. BELTRAN 1940 W. BALT ST, BALT, MD 21223

31. Date filed (Month, Day, Year)

NOV 20 1996

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34934

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Bydume | | | | 2. Date of Death
Month November Day 14 Year 1996 | | 3. Time of Death
3:50 PM | |
| | 4a. Facility Name (If not institution, give street and number)
LEVINDALE NURSEING HOME | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-28-4466 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
62 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
06/17/1934 | 9. Birthplace (State or Foreign Country)
MD. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
6635 HUNTERS WOOD RD. | | | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4or 5+) -0- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABOR | | 16b. Kind of Business/Industry
STEEL | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
OTHA BYDUME | | | | 18. Mother's Name (First, Middle, Maiden Surname)
WILLIE MAE PERRY | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ANNA BYDUME (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6635 HUNTERS WOOD BALTIMORE, MD 21228 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILLS CEM. | | Date
11/20/96 | | 20c. Location - City or Town, State
ESSEX, MD | |
| | 21. Signature of Funeral Service Licensee
<i>Doretha Octu</i> CFSP #281 | | 22. Name and Address of Facility
E.L. PHILLIPS F.H.
1721-27 N. MONROE ST BALTIMORE, MD. 21217 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Small Cell Lung Cancer
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| | Approximate Interval Between Onset and Death
2/96 | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Debra Swertheimer MD</i> | | 29c. License number
D23767 | | 29d. Date signed (Month, Day, Year)
November 15, 1996 | | | |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DEBRA SWERTHEIMER MD, 2434 W. Belvedere Ave, Balt, MD 21215 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
<i>Jana Davidson-Pondell</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1944

1944

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34935

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Berenice Burrows

2. Date of Death

November 18, 1996

3. Time of Death

8:43 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-12-3935

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

6. Date of Birth

4 16 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore, Maryland

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

2448 McCULLOH STREET

10f. Zip Code

21217

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year, or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERK TYPIST

16b. Kind of Business/Industry

HOUSING

17. Father's Name (First, Middle, Last)

CHARLES

HERNDON

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

DYSON

19a. Informant's Name/Relationship (Type, Print)

CYNTHIA BURROWS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2448 McCULLOH ST. BALTIMORE, MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. AUBURN CEMETERY

Date

11/23

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Vernon Bailey

M00014

22. Name and Address of Facility

BAILEY FUNERAL SERVICE

1721-27 N. MONROE ST. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Bowel Infarction

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonas J. Gopez MD

29c. License number

AS2402321JG1974

29d. Date signed (Month, Day, Year)

November 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonas J. Gopez

2401 West Belvedere Baltimore, MD 21215

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

Jonas J. Gopez

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34936

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GENEVA

2. Date of Death

November 17, 1996

3. Time of Death

8:25 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE City

4c. County of Death

n/a

5. Social Security Number

220-30-0215

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 29 1902

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

717 Druid Park Lake Drive

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

High School

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Family

17. Father's Name (First, Middle, Last)

Frank Pegram

18. Mother's Name (First, Middle, Maiden Surname)

Josephine

19a. Informant's Name/Relationship (Type, Print)

Mr. & Mrs. Robert Crawford

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3213 West Strathmore Baltimore, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenview Cemetery

Date

Nov 22 Blackstone, Virginia

21. Signature of Funeral Service Licensee

C. M. R. Fey Jr.

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls Parkway

Baltimore, Maryland 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death

1 week

Due to (or as a consequence of):

Left Lower Lobe Pneumonia

1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pre-Renal Azotemia, Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Graynovskaya

29c. License number

Res. 89270

29d. Date signed (Month, Day, Year)

11/17/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margarita Graynovskaya, M.D. c/o MARYLAND GENERAL Hospital

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34937

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VERONICA J BLUMENSTOCK | | 2. Date of Death
Month: NOV. 11, 1996 Day: Year: | | 3. Time of Death
1248 P |
| | 4a. Facility Name (If not institution, give street and number)
2307 FOSTER AVE. | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
215-03-3040 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
April 6, 1916 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Md. | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number
2307 Foster Ave. | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 yrs. College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home | | |
| | 17. Father's Name (First, Middle, Last)
Francis Bojarski | | 18. Mother's Name (First, Middle, Maiden Surname)
Antoinette Piechochi | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Clayton Blumenstock son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2307 Foster Ave. Baltimore Md. 21224 | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | 20c. Location - City or Town, State
11-19 Baltimore |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility
Connolly Funeral Home Of Dundalk
7110 Sollers Point Rd. 21222 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Antisclerotic Cardiovascular Disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| State Registrar | 29b. Signature and title of certifier
Theodore H. King | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
NOV. 12, 1996 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
THEODORE H. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
J. W. Warden | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



10A 50 100

10A 50 100

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

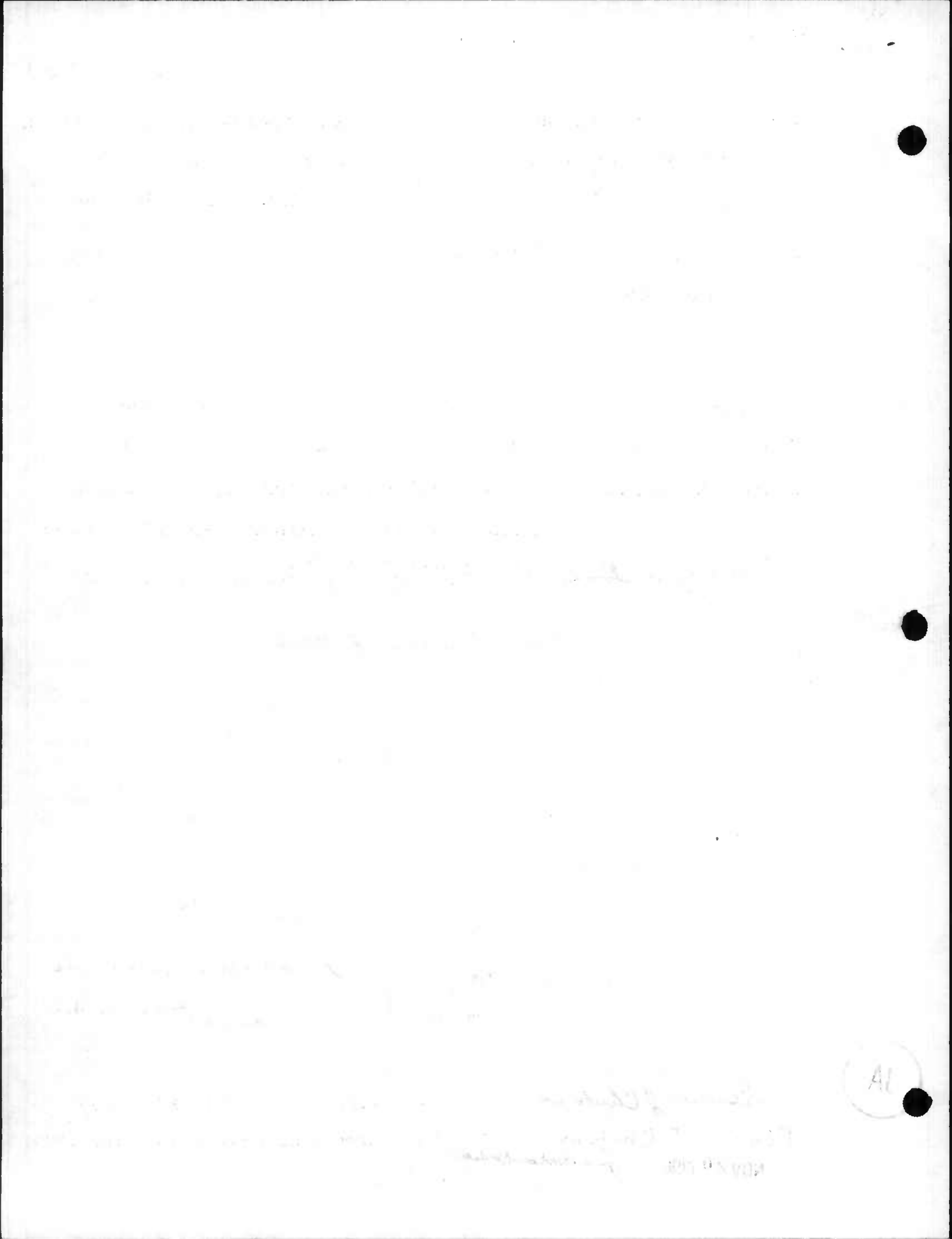
| | | | | | |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
DANIELLE MELISSA MARIE BROWN | | 2. Date of Death
Month NOVEMBER Day 18 Year 1996 | | 3. Time of Death
1:44A.M. | |
| 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS BAYVIEW MEDICAL CENTER | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| 5. Social Security Number
413-06-9575 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
25 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 3, 1971 |
| 9. Birthplace (State or Foreign Country)
Tennessee | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
4416 Lasalle Avenue | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chauffeur | | 16b. Kind of Business/Industry
Self Employed | |
| 17. Father's Name (First, Middle, Last)
Stoy C. Brown, Jr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Beverly Pat Elkins | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Beverly Pat Brown/Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4416 Lasalle Avenue, Baltimore, Maryland 21206 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Location - City or Town, State
11/20/96 Beltsville, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wound of Head
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
11-17-96 | | 28b. Time of Injury
1919 PM | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
self-inflicted gunshot wound | |
| | | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)
Home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
4416 Lasalle Ave Baltimore, Md | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | |
| | | 29d. Date signed (Month, Day, Year)
NOVEMBER 18, 1996 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
 | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 Item: 5, per F.H. G-744 2/4/97 reb
 ITEM#26&28b per physn 11-20-96 film#g741 J.A. **Certificate of Death**

96 34939

Reg. No.

| | | | | | |
|--|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHRISTOPHER BRENNAN | | 2. Date of Death
Month NOV Day 4 Year 96 | | 3. Time of Death
19:00 PM |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY |
| Funeral
Director | 5. Social Security Number
169-80-7306 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
18 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
04/10/78 | | 9. Birthplace (State or Foreign Country)
PA. | | |
| To Be Completed by Funeral Director | 10a. State
PA. | | 10b. County
Monroe | | 10c. City, Town or Location
Blakeslee |
| | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
P.O. Box 125 | | 10f. Zip Code
18610 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Navar Marriad <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
Collega (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | 16b. Kind of Business/Industry
Magazine Co. |
| | 17. Father's Name (First, Middle, Last)
John Brennan | | 18. Mother's Name (First, Middle, Maiden Surname)
Donna Fescina | | |
| | 19a. Informant's Name/Relationship (Type, Print)
John Brennan/ Father | | 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 125 Blakeslee, PA. 18610 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Laurelwood Cem. | | 20c. Location - City or Town, State
11/11/96 Stroudsburg, PA. |
| | 21. Signature of Funeral Service Licensee
<i>Phillip Stach</i> | | 22. Name and Address of Facility
John C. Miller, Inc.
6415 Belair Rd. Baltimore, MD. 21206 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. OVERDOSE MULTIPLE
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
24 HRS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of causa of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
ECONO LODGE MOTEL |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
NOV 03 96 | | 28b. Time of Injury
1430 M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred
TOOK PILLS | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
INOTEL | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
RT 355 GAITHERSBURG MD | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>John C. Miller</i> | | 29c. License number
007099 |
| State Registrar | 29d. Date signed (Month, Day, Year)
NOV 06 96 | | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817 | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten text at the top right, possibly a date or reference number.

Handwritten text in the upper middle section.

Handwritten signature or name in the middle right section.

Handwritten signature or name at the bottom center.

NOV 18 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34940

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WELDON

BROWN SR.

2. Date of Death

Month Day Year
Nov 15 1996

3. Time of Death

8:45a

4a. Facility Name (If not institution, give street and number)

621 NORTH DENISON STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

237-20-2169

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 01, 1918

9. Birthplace (State or Foreign Country)

SC.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

621 NORTH DENISON STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GRINDER

16b. Kind of Business/Industry

BATHROOM FIXTURES

17. Father's Name (First, Middle, Last)

CURTIS BROWN

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL SIMS

19a. Informant's Name/Relationship (Type, Print)

SHELDON D. BROWN (GRDSON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

234 HIGH STREET ROCK HILL, SC. 29730

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CEDAR HILL CEM

Date

11/23/96

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAPLE FUNERAL SERVICE

5502 WINNER AVENUE BALTIMORE, MD. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation

Due to (or as a consequence of):

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Coronary artery disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

few seconds
few minutes
15-20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

HOMAYOON MOHAMMEDI, MD

29c. License number

D17720

29d. Date signed (Month, Day, Year)

11/19/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOMAYOON MOHAMMEDI

1421 S. CATON AVE. BALTO MD 21227

31. Date filed (Month, Day, Year)

NOV 20 1996

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten signature or mark

ITEMS: 8.10f,15,16a,16b, PER STATE ANATOMY BOARD FILM g-744 2/5/97 t.t

96 34941

FOR
STATE
REGISTRAR ITEM; 17, per A.8 G-741 11/19/96
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH^{reb} REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GEORGE W. BURNS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
NOV. 3, 1996 | | 3. TIME OF DEATH
6:00 AM | |
| 4. SOCIAL SECURITY NUMBER
218-48-5631 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
48 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
JUL. 23, 1948 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
232 EDEN ST. | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | |
| 9c. COUNTY OF DEATH
WICOMICO | | | | 10a. STATE
Maryland | | 10b. COUNTY
Wicomico | |
| 10c. CITY, TOWN OR LOCATION
Salisbury | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
232 Eden Street | |
| 10f. ZIP CODE
21801 21804 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
SALES | | 16b. KIND OF BUSINESS/INDUSTRY
AUTOMOBILE | |
| 17. FATHER'S NAME (First, Middle, Last)
Melissa Lear/Niece GEORGE W. BURNS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Melissa Lear/Niece | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
unknown | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) State rem. | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Ronald S. Wade, Director | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board-655 W. Baltimore Street
Baltimore, Maryland 21201-1559 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Malignant lymphoma | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
J. E. Martin, M.D. | | | | 29c. LICENSE NUMBER
030690 | | 29d. DATE SIGNED (Month, Day, Year)
Nov. 4, 1996 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 20 1996 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

6876

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34942

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie Cahill

2. Date of Death

Month
Nov.Day
17Year
96

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

4102 Norfolk Ave

4b. City, Town, or Location of Death

Balto.

4c. County of Death

NA

Funeral
Director

5. Social Security Number

217-26-9768

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-3-14

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4102 Norfolk Ave

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Caterer

16b. Kind of Business/Industry

Balto. City Schools

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Susie Fowkes

19a. Informant's Name/Relationship (Type, Print)

Frank Cooper (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1547 Lochwood Rd. Balto. Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Zion Cemetery 11/29/96

Date

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller P/c FH

1639 N. Broadway
Balto. Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced senile dementia - Alzheimer's type

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

decubitus ulcerations

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

CD Kearney MD

29c. License number

D27860

29d. Date signed (Month, Day, Year)

November 17th 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHRISTOPHER D. KEARNEY 700 WASH BLVD BALT MD 21230

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

John A. [Signature]

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

5-1-75 - 6

OFFICE OF THE
ATTORNEY GENERAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34943

| | | | | | | | | |
|---|--|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Viola Elizabeth Cunningham | | | | 2. Date of Death
Month Day Year
November 19, 1996 | | 3. Time of Death
3:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
5921 Eurith Avenue | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-22-1270 | | 8. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 6. Under 1 Year
Months Days | |
| | 6. Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
Oct. 23, 1927 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
5921 Eurith Avenue | | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4 or 5+)
12th Grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker | | | 16b. Kind of Business/Industry
Own Home | |
| 17. Father's Name (First, Middle, Last)
Herbert Lowes Fisher | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Rosalie MacDonnal | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Husband
Francis Cunningham | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5921 Eurith Avenue, Baltimore, Maryland-21206 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestlawn Cemetery | | 20c. Location - City or Town, State
Marriottsville, MD. | | |
| 21. Signature of Funeral Service Licensee
Kathleen M. Murphy | | | | 22. Name and Address of Facility
6415 Belair Road
John C. Miller, Inc. Baltimore, Maryland-21206 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Metastatic Adenocarcinoma of the Lung
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year)
M | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
Davis M. Hahn MD | | | | 29c. License number
020396 | | 29d. Date signed (Month, Day, Year)
Nov. 19, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Davis M. Hahn, M.D., 5601 Loch Raven Boulevard, Baltimore, Maryland 21239 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
John A. Davidson | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34944

ITEM#24a & 25 PER PHYSN 11-20-96 FLMG741 J.A. Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|---|--|---------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Warren Coats | | | | 2. Date of Death
Month 10 Day 27 Year 96 | | | 3. Time of Death
11:45 PM | | |
| | 4a. Facility Name (If not Institution, give street and number)
Hyattsville Health Care Center | | | | 4b. City, Town, or Location of Death
Hyattsville | | | 4c. County of Death
Prince George's | | |
| Funeral
Director | 5. Social Security Number
577-74-2571 | | 6. Sex
M <input checked="" type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday)
42 Yrs. | | 8. Date of Birth (Month, Day, Year)
7-8-54 | | 9. Birthplace (State or Foreign Country)
Washington, D.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Hyattsville | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
6500 Riggs Road | | | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | | 16b. Kind of Business/Industry
Private | | |
| | 17. Father's Name (First, Middle, Last)
unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
Peggy W. Coates/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1205 Cahpel Oak Drive-Chapel Oaks, Md. 20743 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) State rem. | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board-655 W. Baltimore Street
Baltimore, Maryland 21201-1559 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Aids
Due to (or as a consequence of):</p> <p>b. CMV
Due to (or as a consequence of):</p> <p>c. Pancytopenia
Due to (or as a consequence of):</p> <p>d. Cardiopulmonary Failure</p> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Robert A. Skypworth MD | | | | 29c. License number
D 28906 | | |
| | | | | 29d. Date signed (Month, Day, Year)
10/28/96 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert D. Skypworth MD, 585 MAIN Street, LAUREL, MARYLAND 20707 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
Julia Anderson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMH 16 Rev 6/95

24 A

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34945

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Blanche Natalie Dugger

2. Date of Death
Month Day Year
November 17, 19963. Time of Death
8:30 AM

4a. Facility Name (If not institution, give street and number)

5636 Groveland Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

216-20-8153

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov 12, 1920

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1817 Monroe Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

High School

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

16b. Kind of Business/Industry

Social Security Admin

17. Father's Name (First, Middle, Last)

Colonel Calvin Dugger

18. Mother's Name (First, Middle, Maiden Surname)

Emma R. Whittington

19a. Informant's Name/Relationship (Type, Print)

Carolyn E. Redditt

niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2554 Harlem Avenue Baltimore, Maryland 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Nov 21

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Nutter Funeral Homes, Inc.
2501 Gwynns Falls Parkway
Baltimore, Maryland 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e.

Acute MI

Due to (or as a consequence of):

b.

Diabetes Mellitus

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
8 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAESAR C. SHEDDIAC M.D.

3333 N. CALVERT
BALD - MD. 21218

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

2. [Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

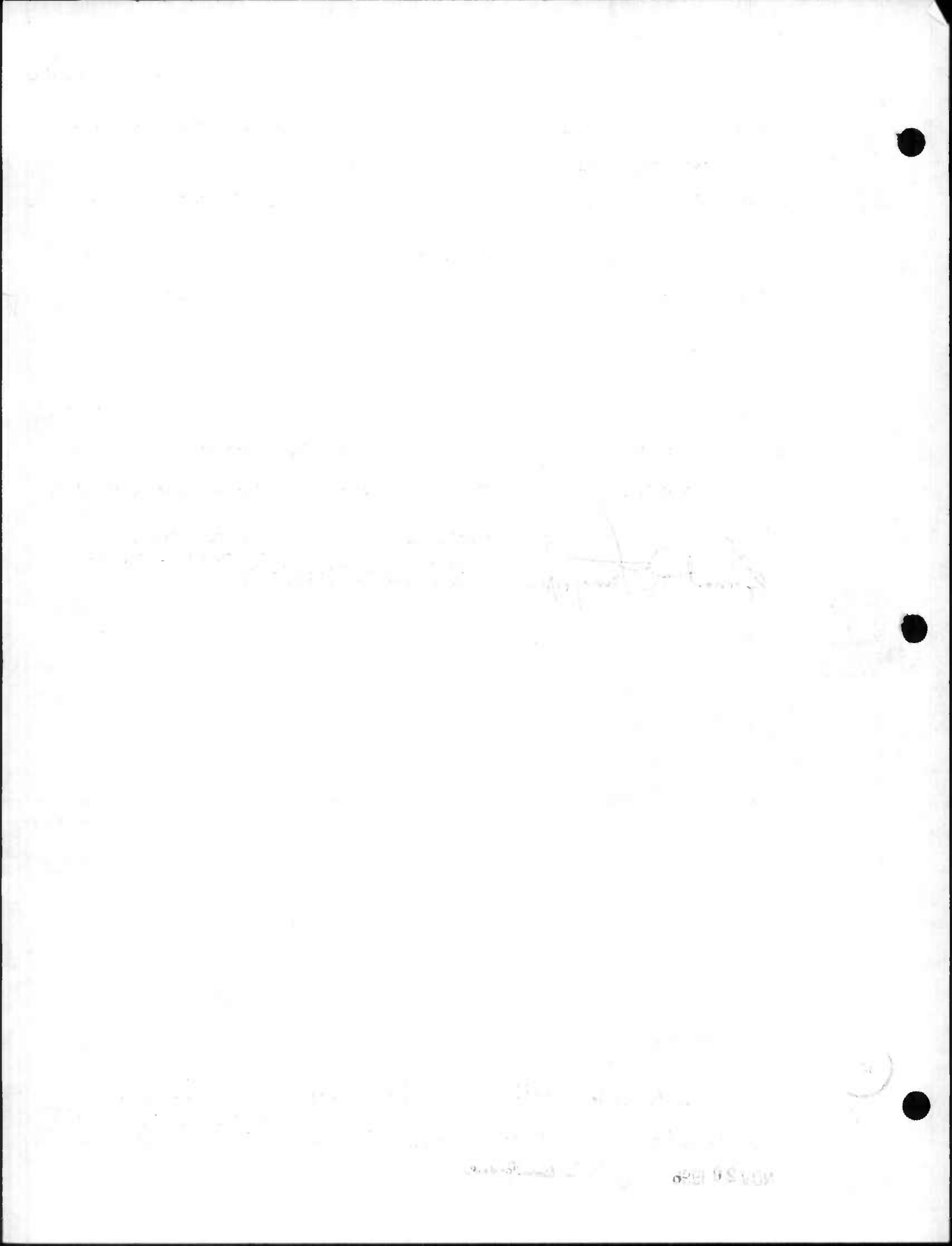
Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34946

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DOROTHY DECATUR | | | | 2. Date of Death
Month Nov. Day 18, Year 1996 | | 3. Time of Death
10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
2633 E. CHASE STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-30-8712 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT. 03, 1932 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10e. State
MARYLAND | | | | | |
| | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | | | | |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number
2633 E. CHASE STREET | | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SUPERVISOR | | 16b. Kind of Business/Industry
SOCIAL SECURITY ADMINISTRATION | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
College (1-4 or 5+) N/A | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
LONNIE DECATUR SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
JULIA BRAXTON | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
LONNIE DECATUR BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2633 E. CHASE ST. BALTO, MD. 21213 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. CALVARY CEM. | | Date
NOV. 25, 1996 | | 20c. Location - City or Town, State
ANNE ARUNDEL CO., MD. | |
| 21. Signature of Funeral Service Licensee
<i>Calvin B. Scruggs, Jr.</i> | | | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD. 21213 | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. <i>Respiratory arrest</i>
Due to (or as a consequence of):
b. <i>Metastatic Carcinoma of Brain / prostate</i>
Due to (or as a consequence of):
c. <i>Carcinoma lung.</i>
Due to (or as a consequence of):
d. <i>> 1 year</i> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Ischemic Heart Disease</i>
<i>Grandmal Epilepsy</i>
<i>Pneumonia Rt. Lung</i> | | | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Guillermo MD</i> | | | | 29c. License number
DB2975 | | 29d. Date signed (Month, Day, Year)
11-19-96 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J.R. RAMAIAH MD 447 N Kenwood Ave. Balt 21224 | | | | | | | |
| | 31. Data filed (Month, Day, Year)
NOV 20 1996 | | | | | | | |
| State Registrar | 32. Registrar's Signature
<i>John R. ...</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

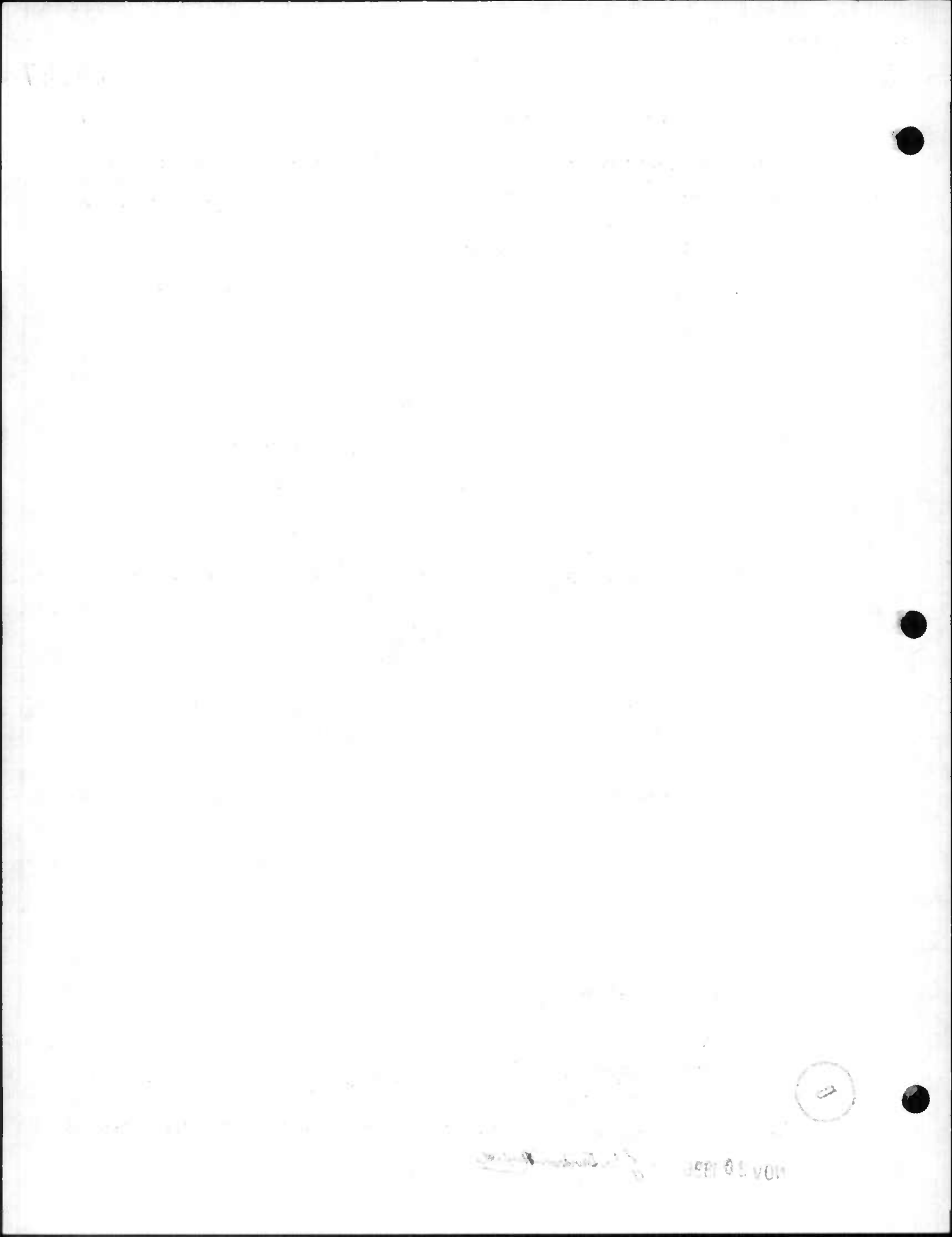
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
JAMES LEROY DEITZ | | 2. Date of Death
Month NOV Day 14 Year 1996 | | 3. Time of Death
2315 P | |
| 4a. Facility Name (If not institution, give street and number)
2600 BLK WEGWORTH AVE | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
Baltimore City |
| 5. Social Security Number
215-84-4519 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
35 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 7, 1961 |
| 9. Birthplace (State or Foreign Country)
Maryland | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Lansdowne | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
3704 Songbird Circle | | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
United States |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 Collage (1-4 or 5+) Collage | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
None (Disabled) | | 16b. Kind of Business/Industry
None | |
| 17. Father's Name (First, Middle, Last)
Franklin D. Deitz, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel M. Springfield | | |
| 19e. Informant's Name/Relationship (Type, Print)
Lisa Deitz / Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7325 Harford Rd., Baltimore, Maryland | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cemetery | | 20c. Date
November 19, 1996 | |
| 20d. Location - City or Town, State
Baltimore, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home
421 Crain Hwy., S.E., Glen Burnie, MD 21061 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Gun shot Wounds
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
11-14-96 | | 28b. Time of Injury
2254 M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
subject shot | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2600 BLK WEGWORTH RD | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
NOVEMBER 15, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
 | | | |



1

NOV 30 1956

ITEM#5 PER. F.H. 11-26-96 J.A.

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

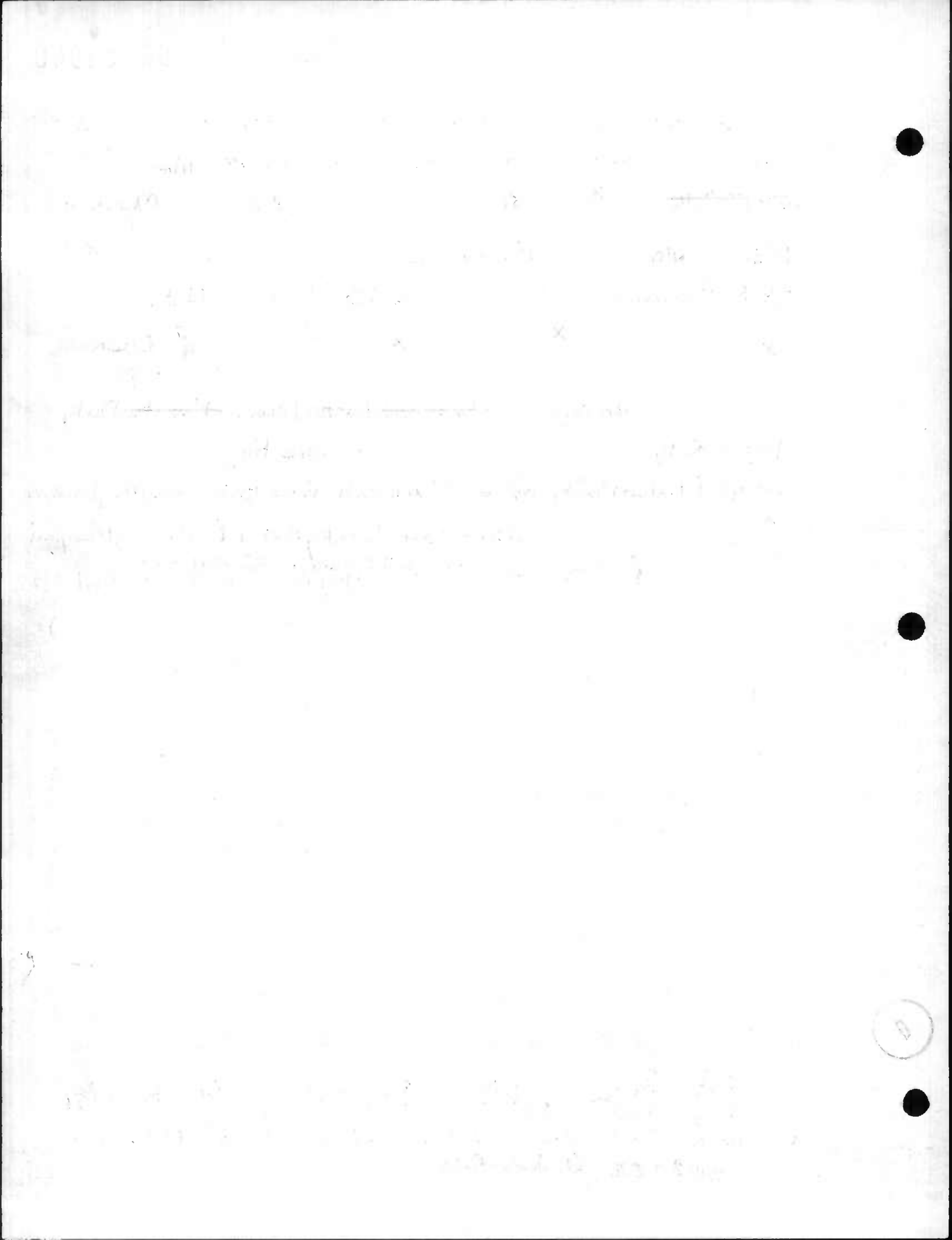
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
LOTTIE K DOWNEY | | 2. Date of Death
Month NOV Day 19 Year 1996 | | 3. Time of Death
3:35Am | |
| 4e. Facility Name (If not institution, give street and number)
BON SECOURS HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| 5. Social Security Number
214-18-5014 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
8-13-13 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| 10e. Street and Number
48 N. Gorman | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) A.A. Degree | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LICENSED Practical Nurse | |
| 16b. Kind of Business/Industry
PRIVATE | | 17. Father's Name (First, Middle, Last)
Roger King | | 18. Mother's Name (First, Middle, Maiden Surname)
Fannie King | |
| 19a. Informant's Name/Relationship (Type, Print)
Joseph P. Parham Sr. (Stepson) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2201 Monticello Road, Baltimore, Maryland 21216 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Auburn Cemetery | | 20c. Location - City or Town, State
11-23-96 Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee
[Signature] | | 22. Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Avenue, Baltimore, Maryland 21217 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute bacterial endocarditis - staph aureus
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hypertensive arteriosclerotic heart disease
Due to (or as a consequence of):
c. End stage renal disease
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertensive arteriosclerotic heart disease
End stage renal disease | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] MD | | 29c. License number
D16263 | |
| 29d. Date signed (Month, Day, Year)
Nov. 19, 1996 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JUAN A. BELTRAN 1940 W. BALT ST, BALT, MD 21223 | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
[Signature] | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34949

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|--|--|---|---------------------------------|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Lois Edelstein</u> | | | | 2. Date of Death
Month <u>November</u> Day <u>12</u> Year <u>1996</u> | | | | 3. Time of Death
<u>5:20 pm</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | | 4b. City, Town, or Location of Death
<u>BALTIMORE CITY</u> | | | | 4c. County of Death
<u>N/A</u> | |
| Funeral
Director | 5. Social Security Number
<u>212-32-8424</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>61</u> Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
<u>MAR.10,1935</u> | | 9. Birthplace (State or Foreign Country)
<u>MARYLAND</u> | | 10a. State
<u>MD</u> | | 10b. County
<u>BALTIMORE</u> | | 10c. City, Town or Location
<u>BALTIMORE</u> | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
<u>3100 OLD POST DR.</u> | | 10f. Zip Code
<u>21208</u> | | 10g. Citizen of What Country?
<u>USA</u> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>WHITE</u> | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>ADMINISTRATIVE ASSISTANT</u> | | 16b. Kind of Business/Industry
<u>MD STATE POLICE</u> | | 17. Father's Name (First, Middle, Last)
<u>MORRIS ZWEIGEL</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>MINNIE PEIROSS</u> | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>ROBERT EDELSTEIN (SON)</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>123 SUNNY MEADOW LANE REISTERSTOWN, MD 21136</u> | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>ARLINGTON (CHIZUK AMUNO)</u> | | 20c. Location - City or Town, State
<u>11/14/1996 BALTO., MD</u> | | |
| 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | 22. Name and Address of Facility
<u>SOL LEVINSON & BROS., INC.</u>
<u>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</u> | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. <u>pneumonia</u>
Due to (or as a consequence of):

b. <u>metastatic lung cancer</u>
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
<u>24 hours</u>
<u>15 months</u> | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
<u>11/12/96</u> | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>[Signature]</u> | | 29c. License number
<u>RES-000</u> | | |
| 29d. Date signed (Month, Day, Year)
<u>11/12/96</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Smitha Subramanyan Oncology 126, Johns Hopkins Hospital</u> | | 31. Date filed (Month, Day, Year)
<u>Nov 20 1996</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34950

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---------------------------|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HELEN B FELDMAN | | | | 2. Date of Death
Month NOV. Day 13 Year 1996 | | 3. Time of Death
9:38 AM | |
| | 4a. Facility Name (If not institution, give street and number)
6317 PARK HEIGHTS AVE., APT. 604 | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
220-22-8249 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JAN. 24, 1910 | 9. Birthplace (State or Foreign Country)
W. VIRGINIA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
6317 PARK HEIGHTS AVE., APT. 604 | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
INVESTOR | | 16b. Kind of Business/Industry
REAL ESTATE | | |
| 17. Father's Name (First, Middle, Last)
ALEXANDER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BLUMBERG FANNIE GROSSMAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DAVID H. FELDMAN (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2220 SHEFFLIN CT. BALTIMORE, MD 21209 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON (CHIZUK AMUNO) | | Date
11/14/96 | | 20c. Location - City or Town, State
BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Acute MYOCARDIAL INFARCTION Acute
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Acute MYOCARDIAL INFARCTION Acute
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
010246 | | 29d. Date signed (Month, Day, Year)
11/13/96 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
23 CROSS AVE. BALTO, OWINGS MILLS MD 21115 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

ITEM: 1. PER FACILITY FILM g-741
11/20/96 t.t 11. PER F.H.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34951

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
<u>Green Victoria</u> VICTORIA GREER | | 2. Date of Death
Month <u>November</u> Day <u>7</u> Year <u>1996</u> | | 3. Time of Death
<u>3: PM</u> | |
| 4a. Facility Name (If not institution, give street and number)
<u>Evergreen Nursing & Rehab Center</u> | | 4b. City, Town, or Location of Death
<u>Baltimore, MD</u> | | 4c. County of Death
<u>NA</u> | |
| 5. Social Security Number
<u>058-22-1074</u> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>79</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month Day Year
<u>July 19, 1917</u> |
| 9. Birthplace (State or Foreign Country)
<u>VA</u> | | | | | |
| 10a. State
<u>MD</u> | | 10b. County
<u>NA</u> | | 10c. City, Town or Location
<u>Baltimore</u> | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
<u>1821 Walbrook Avenue</u> | | 10f. Zip Code
<u>21217</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>11th grade</u>
College (1-4 or 5+) <u>NA</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Presser</u> | | 16b. Kind of Business/Industry
<u>Laundry</u> | |
| 17. Father's Name (First, Middle, Last)
<u>Richard Thornton</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Fannie Terrell</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Jake Allen - Son</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>91 Jefferson Street Paterson, N.J. 07522</u> | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Garrison Forest Vet</u> | | 20c. Location - City or Town, State
<u>11-13-96 Owings Mills, md</u> | |
| 21. Signature of Funeral Service Licensee
<u>Sala March</u> | | 22. Name and Address of Facility
<u>March F.H. West 4300 Wabash Avenue Baltimore 21215</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. <u>hypertension</u>
Due to (or as a consequence of): | | | | | |
| b. <u>renal failure</u>
Due to (or as a consequence of): | | | | | |
| c. <u>metastatic colon cancer</u>
Due to (or as a consequence of): | | | | | |
| d. | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of Certifier
<u>John W. Miller MD</u> | | 29c. License number
<u>D07421</u> | | 29d. Date signed (Month, Day, Year)
<u>11/12/96</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Louis Miller 2525 W. Belvedere 21215</u> | | | | | |
| 31. Date filed (Month, Day, Year)
<u>NOV 20 1996</u> | | 32. Registrar's Signature
<u>John Davidson-Randall</u> | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34952

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HOMER GAGAN

2. Date of Death

Month

Day

Year

NOVEMBER 17

1996

3. Time of Death

11:09 PM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

5. Social Security Number

213-41-1439

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 23, 1955

9. Birthplace (State or Foreign Country)

Phillippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

865 Darby Farms Dr.

10f. Zip Code

21144

10g. Citizen of What Country?

Phillippines

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Waiter

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Ben-Hur O. Gagan

18. Mother's Name (First, Middle, Maiden Surname)

Floresfida O. Ongoco

19a. Informant's Name/Relationship (Type, Print)

Alice Magday / Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

535 Pasture Brook Rd. Severn, MD 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Divilupihan Bataan Cem.

Date

Nov. 23, 1996

20c. Location - City or Town, State

Phillippines

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home

421 Crain Hwy. S.E. Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. HYPOXIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

one week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. PULMONARY HYPERTENSION

Due to (or as a consequence of):

one year

c. VENTRICULAR SEPTAL DEFECT

Due to (or as a consequence of):

40 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

P08655

29d. Date signed (Month, Day, Year)

NOVEMBER 17, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN FISH MD 22 SOUTH GREENE STREET BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

20.12.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34953

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERMAN

GRESSER

2. Date of Death

Month Day Year
NOV. 16 1996

3. Time of Death

7:45 AM

4a. Facility Name (If not institution, give street and number)

2713 SUMMERSON RD.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216-07-1079

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
APR. 13, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2713 SUMMERSON RD.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

DISTRIBUTOR

16b. Kind of Business/Industry

DRY CLEANING & LAUNDRY SUPPLIES

17. Father's Name (First, Middle, Last)

DAVID

GRESSER

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

KATZEN

19a. Informant's Name/Relationship (Type, Print)

DORIS GRESSER (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2713 SUMMERSON RD. BALTIMORE, MD 21209

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON (CHIZUK AMUNO)

Date

11/17/96

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Metastatic adenocarcinoma unknown primary

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24888

29d. Date signed (Month, Day, Year)

Nov. 16, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Friedman MD 4000 Old Court Rd #306 Balt. MD 21208

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

070-92



Certificate of Death

Reg. No.

| | | | | | | | |
|--|---|---------------------------------|--|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Baby Jordan Hines</u> BABY JORDAN HINES-BURRIS | | | | 2. Date of Death
Month <u>10</u> Day <u>30</u> Year <u>96</u> | | 3. Time of Death
<u>2043</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>University of Maryland</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore, City</u> | | 4c. County of Death
<u>N/A</u> |
| Funeral
Director | 5. Social Security Number
<u>N/A</u> | 6. Sex
<u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday)
<u>0</u> Yrs. | If Under 1 Year
Months <u>1</u> Days <u>1</u> | If Under 24 Hrs.
Hours <u>1</u> Min. <u>0</u> | 8. Date of Birth (Month/Day, Year)
<u>10/29/96</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>Balt, Maryland</u> | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | |
| | 10a. State
<u>Maryland</u> | | 10b. County
<u>N/A</u> | | 10c. City, Town or Location
<u>Baltimore</u> | | 10d. Inside City Limits
<u>1</u> Yes <u>2</u> No |
| | 10e. Street and Number
<u>3447 Kenyon Ave.</u> | | | 10f. Zip Code
<u>21213</u> | | 10g. Citizen of What Country?
<u>USA</u> | |
| | 11. Marital Status
<u>1</u> Never Married <u>2</u> Married
<u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<u>1</u> Yes <u>2</u> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<u>1</u> Yes <u>2</u> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Afro-American</u> |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u> | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry | |
| | 17. Father's Name (First, Middle, Last)
<u>Walter Burris Jr.</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Taj Hines</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>Mrs. Joann Burris</u> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>6847 Parsons Ave. Balto. Md. 21207</u> | | | |
| | 20a. Method of Disposition
<u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State
<u>4</u> Donation <u>5</u> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Mt. Zion (Babylonia)</u> | | 20c. Location - City or Town, State
<u>11/7/96 Lansdowne, Md.</u> | | |
| | 21. Signature of Funeral Service Licensee
<u>Joseph L. Russ</u> | | | 22. Name and Address of Facility
<u>Joseph L. Russ Funeral Home</u>
<u>2222 W. North Ave. Balto. Md. 21216</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>a. Potter's Syndrome</u>
Due to (or as a consequence of):
<u>b. Urinary Outflow Obstruction</u>
Due to (or as a consequence of):
<u>c.</u>
Due to (or as a consequence of):
<u>d.</u>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<u>Pulmonary Hypoplasia</u> | | | | | | |
| 23b. Approximate interval between Onset and Death
<u>24 hrs</u>
<u>?</u> | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Pulmonary Hypoplasia</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown |
| | 24a. Was an autopsy performed?
<u>1</u> Yes <u>2</u> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<u>1</u> Yes <u>2</u> No |
| | 25. Was case referred to medical examiner?
<u>1</u> Yes <u>2</u> No | | 26. Place of Death (Check only one)
Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | | |
| | 27. Manner of Death
<u>1</u> Natural <u>5</u> Pending Investigation
<u>2</u> Accident <u>6</u> Could not be determined
<u>3</u> Suicide <u>4</u> Homicide | | 28a. Date of Injury (Month, Day, Year)
<u>10/30/96</u> | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<u>1</u> Yes <u>2</u> No |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | 29b. Signature and title of certifier
<u>Kevin Mahon, MD</u> | | 29c. License number
<u>DH7536</u> | | 29d. Date signed (Month, Day, Year)
<u>10/30/96</u> | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Kevin Mahon, MD, Division of Neurology, 22 S. Greene St Balt MD 21201</u> | | | | | | |
| | 31. Date filed (Month, Day, Year)
<u>NOV 20 1996</u> | | 32. Registrar's Signature
<u>John Andrew Randall</u> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34955

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Walter Franklin Heckcrote | | | | 2. Date of Death
Month: November Day: 18 Year: 1996 | | 3. Time of Death
9:00 am | | | |
| | 4a. Facility Name (If not institution, give street and number)
Overlea Gardens Nursing Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | |
| Funeral
Director | 5. Social Security Number
220-20-5072 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 20, 1927 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10e. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10e. Street and Number
4335 Parkton Street | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1950-1952 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10 College (1-4 or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Police Officer | | 16b. Kind of Business/Industry
Law Enforcement | | | |
| | 17. Father's Name (First, Middle, Last)
Harem Heckcrote | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva I. Gillepsie | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
Mr. Edgar Heckcrote/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5608 Benton Heights Avenue Baltimore, Md. 21206 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | Date
11/21/96 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Mark T. Ziegler | | | | 22. Name and Address of Facility
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Encephalopathy Metabolic</u>
Due to (or as a consequence of):
b. <u>Alcoholism</u>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Cerebral Vascular Accident</u>
<u>Chronic Obstructive Lung Disease</u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Howard H Bond MD | | 29c. License number
D19793 | | 29d. Date signed (Month, Day, Year)
Nov 19, 1996 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Howard H Bond MD 9618 Belair Road Baltimore Md | | | | | | | | 31. Date filed (Month, Day, Year)
NOV 20 1996 | |
| | 32. Registrar's Signature
Jung Davidson-Rendella | | | | | | | | 31. Date filed (Month, Day, Year)
NOV 20 1996 | |

Gate: 0.5 V/V

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34956

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--------------------------|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Frank E Heckrotte | | | | 2. Date of Death
Month November Day 18 Year 1996 | | | | 3. Time of Death
10:00AM | |
| | 4a. Facility Name (If not institution, give street and number)
3015 Alabama Avenue | | | | 4b. City, Town, or Location of Death
N/A | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-52-4228 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
45 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan 29 1951 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore Co. Maryland | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
3015 Alabama Avenue | | | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 th College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Fork Lift Operator | | | 16b. Kind of Business/Industry
Warehouse | | |
| | 17. Father's Name (First, Middle, Last)
Joseph H Hechrotte Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Doris L Mason (Schaumburg) | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
James Jacob Jones Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Apt 107 Sunset Manor Ridgley Md 21660 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | Date
11-22-96 | | 20c. Location - City or Town, State
Baltimore Md. | | | |
| | 21. Signature of Funeral Service Licensee
Jody D Smith | | | | 22. Name and Address of Facility
Hartley Miller Funeral Home
7527 Harford Rd Baltimore Md 21234 | | | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Coronary artery disease</u>
Due to (or as a consequence of):
b. <u>diabetes</u>
Due to (or as a consequence of):
c. <u>hypertension</u>
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
yes | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
N/A | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
N/A | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Edward, MD | | | | 29c. License number
046039 | | 29d. Date signed (Month, Day, Year)
11/20/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
516 N Rolling Road #105
Baltimore, MD 21228 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | | | | | | | |
| 32. Registrar's Signature
Jung Davidson-Randall | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34957

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Luther Hampe

2. Date of Death
Month Day Year

Nov. 18 1996

3. Time of Death

2:00pm

4a. Facility Name (If not institution, give street and number)

St. Agnes Hosp.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

209-10-0825

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 21, 1919

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

4101 Asbury Ave.

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10 yrs.

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Photo

17. Father's Name (First, Middle, Last)

Edward Hampe

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Ellen Gray

19a. Informant's Name/Relationship (Type, Print)

Rita Vitilio daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4101 Asbury Ave. Baltimore Md. 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

11-20

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

John E. Miller

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk
7110 Sollers Point Rd. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARCINOMA Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. LIVER METASTATIC Disease

Due to (or as a consequence of):

5 yr

c. CHRONIC OBSTRUCTIVE Pulmonary Disease

Due to (or as a consequence of):

10 yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony R. Doti

29c. License number

P09886

29d. Date signed (Month, Day, Year)

Nov, 18, 1996

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Anthony R. Doti 900 CATON AVE BALIT MD 21229

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death. To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34958

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|--|--|--|--|---|------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
L V JACKSON | | | | 2. Date of Death
Month: Nov, Day: 14, Year: 1996 | | | | 3. Time of Death
11:17 AM | |
| | 4a. Facility Name (If not institution, give street and number)
705 N. Linwood Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
424-40-2629 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 | 8. Date of Birth
Month: May, Day: 27, Year: 1932 | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | Usual Residence of Decedent
10a. State: Maryland 10b. County: N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
Construction Co. | | | | | | |
| 17. Father's Name (First, Middle, Last)
ELIAS JACKSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Susie Caver | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
TONTALAYA MIXON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
626 Greene Toledo, Ohio 43609 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | 20c. Date
11/22 | | 20d. Location - City or Town, State
Arbutus Md. | | | | |
| 21. Signature of Funeral Service Licensee
Blair Adams | | 22. Name and Address of Facility
Jones Marshall W. Jones Jr. Funeral Hm
4101 Edmondson Ave. Baltimore, Md. 21229 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. CARCINOMA OF STOMACH
Due to (or as a consequence of):
b. <i>di</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Anil Uberoi MD | | 29c. License number
D26748 | | 29d. Date signed (Month, Day, Year)
11/13/96 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANIL UBEROI MD 4419, FALLS RD BALTO MD 21211 | | 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34959

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|--|---|---|---|-----------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROSA LEE LUCKETT | | | 2. Date of Death
Month Day Year
NOVEMBER 19, 1996 | | 3. Time of Death
2:42 AM | |
| | 4a. Facility Name (If not institution, give street and number)
2646 WEST LAFAYETTE AVE. | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
226-22-2416 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 6, 1929 |
| | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2646 West Lafayette Avenue | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
8th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cook | | 16b. Kind of Business/Industry
Various Restaurants | | |
| | 17. Father's Name (First, Middle, Last)
Thomas Worrell | | | 18. Mother's Name (First, Middle, Maiden Surname)
Blanche Williams | | | |
| | 19a. Informant's Name/Relationship (Type, Print) daughter
Geraldine Bell | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2646 West Lafayette Avenue Baltimore, MD 21216 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Roosevelt Memorial Cem, Nov 23 | | 20c. Location - City or Town, State
Chesapeake, Virginia | | |
| | 21. Signature of Funeral Service Licensee
<i>Ernest R. Ferry</i> | | 22. Name and Address of Facility
Nutter Funeral Homes, Inc.
2501 Gwynns Falls Parkway
Baltimore, Maryland 21216 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Atherosclerotic Cardiovascular Disease</i>
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| | 24a. Was an autopsy performed?
Inspection
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| State Registrar | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | 29b. Signature and title of certifier
<i>Stephen S. Radentz, MD</i> | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
NOVEMBER 19, 1996 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| | 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
<i>Gene Davidson</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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1-10-10

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020000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34960

Reg. No.

| | | | | | | | | |
|---|---|---------------------------|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DR. SIDNEY LIEBERMAN | | | | 2. Date of Death
Month NOV. Day 11 Year 1996 | | 3. Time of Death
2:35 PM | |
| | 4a. Facility Name (If not institution, give street and number)
6210 PARK HEIGHTS AVE., APT. 805 | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-38-4863 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
APR. 5, 1913 | |
| | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
6210 PARK HEIGHTS AVE., APT. 805 | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DENTIST | | 16b. Kind of Business/Industry
DENTISTRY | | |
| 17. Father's Name (First, Middle, Last)
ABRAHAM LIEBERMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BLANCHE LIEBERMAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MIGNON LIEBERMAN (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6210 PARK HEIGHTS AVE., APT. 805 BALTO., MD 21215 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HEBREW FRIENDSHIP | | Data
11/14/1996 | | 20c. Location - City or Town, State
BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RENAL CELL CANCER
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death
2 YEARS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
MD | | | 29c. License number
D29373 | | | 29d. Date signed (Month, Day, Year)
11/12/96 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ERIC J. SEIFTER 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Registrar Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

0000000000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34961

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy J. Mills

2. Date of Death

November 20 1996

3. Time of Death

12:34 AM

4a. Facility Name (If not institution, give street and number)

4 Urbanwood Court

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-30-5501

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 27, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Urbanwood Court

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Theodore Merchel

18. Mother's Name (First, Middle, Maiden Surname)

Julia E. Gutcher

19e. Informant's Name/Relationship (Type, Print)

Jack Mills (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Urbanwood Court Essex, Maryland 21221

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens 11/22/1996

Date

20c. Location - City or Town, State

Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Brudzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Malignant Carcinoma

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

11 mths

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18487

29d. Date signed (Month, Day, Year)

November 20, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237

31. Date filed (Month, Day, Year)

NOV 20 1996

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34962

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN L MILLER

2. Date of Death
Month Day Year
NOV. 18, 19963. Time of Death
1729 P

4e. Facility Name (If not institution, give street and number)

1716 N. CHAPEL ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

247-54-2011

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 26, 1932

9. Birthplace (State or Foreign Country)

CLINTON, SC

Usual Residence of Decedent

10a. State
MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1716 CHAPEL STREET

10f. Zip Code

21213

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 th

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

L.T.DIGGS(DRIGGS)

17. Father's Name (First, Middle, Last)

CLEVELAND MILLER

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE REE BLAKLEY

19a. Informant's Name/Relationship (Type, Print)

CLEVELAND MILLER J.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

92 LAWSON STREET, HEMPSTEAD, NY 11550

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BETHLEHEM GROVE BAPT. CH. 11-24-96 CLINTON, SC

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM. C. MARCHFH.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?

INSPECTION

☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

NOV. 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN RADENTZ MD 111 PENN STREET, BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

220

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34963

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH

MCCRONE

2. Date of Death

Month Day Year
Nov. 18 1996

3. Time of Death

5:20 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Manor Care Ruxton

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-76-5297

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
March 19, 1895

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

7001 N. Charles St.

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John

18. Mother's Name (First, Middle, Maiden Surname)

Leitch

Elizabeth

Keech

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary Ellen Hale Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36 Bussing Ct. Timonium, Md. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

11/21/96

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Robert M. Kratz

22. Name and Address of Facility

Mitchell-Wiedefeld Home Inc.
6500 York Rd. Balto. Md. 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Congestive Heart Failure

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Khin M. Tun

29c. License number

D-17992

29d. Date signed (Month, Day, Year)

11/19/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khin M. Tun MD 1006 Taylor Ave. Baltimore, Maryland 21286

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

John F. Gordon

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

State
Registrar


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

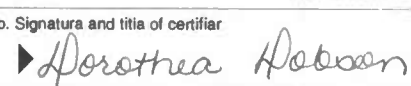

State of Maryland / Department of Health and Mental Hygiene

96 34964

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lee Moffett | | | | 2. Date of Death
Month November Day 15 Year 1996 | | 3. Time of Death
1045AM | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
214-16-5559 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCT. 26, 1918 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
7609 CARLA RD. | | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALESMAN | | 16b. Kind of Business/Industry
LIQUOR | | | |
| | 17. Father's Name (First, Middle, Last)
ABRAHAM MOFFETT | | | | 18. Mother's Name (First, Middle, Maiden Surname)
SOPHIE BALSER | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
MRS. SHIRLEY E. MOFFETT (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7609 CARLA RD. BALTIMORE, MD 21208 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SHAAREI ZION | | 20c. Location - City or Town, State
11/17/96 ROSEDALE, MD | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Metastatic Pancreatic Cancer</p> <p>b. Pulmonary Edema</p> <p>c. </p> <p>d. </p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p>2 years</p> <p>3 days</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
AS2402321-DD9030 | | 29d. Date signed (Month, Day, Year)
November 15, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DOROTHEA DOBSON, M.D. SINAI HOSPITAL BALTIMORE, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 900-84.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 900-84.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34965

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARIE NICHOLAS | | 2. Date of Death
Month November Day 18 Year 1996 | | 3. Time of Death
11:50A |
| | 4a. Facility Name (If not institution, give street and number)
Meridian Loch Raven | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
216-28-4080 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
96 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
October 24, 1900 | | 9. Birthplace (State or Foreign Country)
Greece | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No XXX |
| | 10e. Street and Number
5218 McFaul Road | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced
XX | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: XX | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: XX |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) College | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | 16b. Kind of Business/Industry
Clothing | | |
| | 17. Father's Name (First, Middle, Last)
Demetrios Yeatris | | 18. Mother's Name (First, Middle, Maiden Surname)
Georgia Diakoumakos | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Marion T Karavedas Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5218 McFaul Road Baltimore, Maryland 21206 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greek Orthodox Cemetery | | 20c. Location - City or Town, State
11/21/96 Baltimore, Maryland |
| | 21. Signature of Funeral Service Licensee
Dennis J. Kenakis | | 22. Name and Address of Facility
Mitchell-Wiedefeld Home
6500 York Road Baltimore, Maryland 21212 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Anemia
Due to (or as a consequence of):
b. Vaginal Bleeding
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
2 months
6 months | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
P. A. Baltatzis MD | | 29c. License number
D-28949 | | 29d. Date signed (Month, Day, Year)
November 19, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Panayiotis A. Baltatzis 8113 Harford Road Baltimore, Maryland | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

2000

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the research and the objectives of the study.

2. The second part of the report is a detailed description of the methodology used in the study. It includes information about the sample size, the data collection methods, and the statistical analysis techniques used.

3. The third part of the report is a discussion of the results of the study. It compares the findings with the previous research and discusses the implications of the results.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34966

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANK OLSZEWSKI

2. Date of Death

November 15, 1996

3. Time of Death

8:37PM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

217-01-4910

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 1, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2125 Middleborough Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John Olszewski

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Purcell

19a. Informant's Name/Relationship (Type, Print)

Mary Olszewski (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2125 Middleborough Rd., Essex, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery 11/18/1996

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Coronary Artery Disease

7months

Due to (or as a consequence of):

b. Cancer of mouth

20months

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30951

29d. Date signed (Month, Day, Year)

11-18-96

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Angelo Lucco, M.D. Perry Point VAAMC, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

000000 00

NOV 5 1936

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34967

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|--|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LUKE PORTER | | 2. Date of Death
Month NOV. Day 17 Year 1996 | | 3. Time of Death
3:00 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
1725 CLIFTVIEW AVENUE | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
213-20-9924 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
FEB. 7, 1927 | | 9. Birthplace (State or Foreign Country)
SOUTH CAROLINA | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore |
| | 10d. Inside City Limits
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1725 Cliftview Avenue | | |
| | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th grade College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Ship Paint | | 16b. Kind of Business/Industry
Bethlehem Steel | | |
| | 17. Father's Name (First, Middle, Last)
Luke Porter | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Grant | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Darlene Porter (daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1725 Cliftview Avenue, Baltimore, Maryland 21213 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Auburn Cemetery 11-22-96 Baltimore, Maryland | | 20c. Location - City or Town, State |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVENUE, BALTIMORE, MD. 21217 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Diffuse Liver Metastasis | | | | Approximate Interval Between Onset and Death
2 mo
2 mo |
| | Due to (or as a consequence of):
Probable Colon Carcinoma | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | |
| 28b. Time of Injury
M | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | | | | |
| 29c. License number
D31650 | | | | | |
| 29d. Date signed (Month, Day, Year)
11/20/96 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN GUTHEIL 22 S. GREENE ST. BALTO. MD. 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

05 NOV 1991

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34968

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Arnie Penn, Sr.

2. Date of Death
Month Day Year

Nov. 17, 1996

3. Time of Death
6:00A.M.

4a. Facility Name (If not institution, give street and number)

4858 Sykesville Road

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

215 22 8239

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

Aug. 9, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Md.

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4858 Sykesville Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Navar Married ☐ Married
☐ Widowed ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☒ Yes ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Construction Superintendent

16b. Kind of Business/Industry

East Coast
Construction

17. Father's Name (First, Middle, Last)

Windom Penn

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Sheckels

19a. Informant's Name/Relationship (Type, Print)

Nancy Ellen Penn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4858 Sykesville Rd. Sykesville, MD. 21784

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Carroll Cremation

Date

11/18/96

20c. Location - City or Town, State

Hampstead, MD.

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home
P.O. Box 195 Sykesville, Md.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. CORONARY THROMBOSIS
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

IMMED

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. ATHEROSCLEROTIC CORONARY HEART DISEASE
Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicida ☐ Homicida28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vincent J. Fiocco Jr MD

29c. License number

D01663

29d. Date signed (Month, Day, Year)

11/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VINCENT J. FIOCCO JR

8 ANCHOR ST

WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

John Davidson

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
The Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

541

State
Registrar

Al

NOV 24 1994

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34969

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GENEVIEVE,

Genevieve Pucci

~~PUCCI~~

2. Date of Death

Month
06Day
26Year
96

3. Time of Death

8:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

5. Social Security Number

219-18-8990

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Yr

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 30, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6116 Belair Road

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Pharmaceutical

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Andrew L. Buettner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

280 Bowline Road-Severna Park, Maryland 21146

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

State rem.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Nansant

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street
Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CELLULITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37254

29d. Date signed (Month, Day, Year)

6/27/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM, MD 7620 YORK ROAD TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JUL 11 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 9. PER F.H. FILM G-741

State of Maryland / Department of Health and Mental Hygiene

96 34970

11/20/96 t.t

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Elora Perry</u> | | | | 2. Date of Death
Month <u>11</u> Day <u>16</u> Year <u>96</u> | | 3. Time of Death
<u>6:00pm</u> | |
| | 4e. Facility Name (If not institution, give street and number)
<u>725 George St. 11C</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
<u>225-22-5339</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>73</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>May 6, 1923</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>NORTH CAROLINA</u> | | 10a. State
<u>Maryland</u> | | 10b. County
<u>Baltimore</u> | | 10c. City, Town or Location
<u>Baltimore</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
<u>725 George St. 11C</u> | | 10f. Zip Code
<u>21201</u> | | 10g. Citizen of What Country?
<u>USA</u> | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | |
| To Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed)
<u>9th Grade</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Laundry Worker</u> | | 16b. Kind of Business/Industry
<u>Hagyard's Laundry</u> | | 17. Father's Name (First, Middle, Last)
<u>Unknown</u> | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Unknown</u> | | 19. Informant's Name/Relationship (Type, Print)
<u>Grover Perry</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>155 Cleveland St. Baltimore, MD, 21230</u> | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Meadow Ridge Cem.</u> | | 20c. Location - City or Town, State
<u>Elkridge, Maryland</u> | | 21. Signature of Funeral Service Licensee
<u>Kevin Parker</u> | | 22. Name and Address of Facility
<u>Kevin A. Parker Funeral Home</u>
<u>3512 Frederick Avenue</u>
<u>Baltimore, md 21229</u> | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>CORONARY ARTERY DISEASE</u>
Due to (or as a consequence of):
<u>HYPERTENSION</u>
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
<u>4 YRS</u>
<u>4 YRS</u> | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
<u>11/22/96</u> | |
| | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<u>John Davidson-Randall</u> | | 29c. License number
<u>D36031</u> | | 29d. Date signed (Month, Day, Year)
<u>11/19/96</u> | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>DONNA L. PARKER, MD</u> | | 31. Date filed (Month, Day, Year)
<u>NOV 20 1996</u> | | 32. Registrar's Signature
<u>John Davidson-Randall</u> | | 33. Date of Death
<u>11/22/96</u> | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

05176

[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side.]

Certificate of Death

Reg. No.

96 34971

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) de Murguiondo

AMALIA ~~de MURQUIONDO~~ RIGGS

2. Date of Death

Month Day Year
November 12, 1996

3. Time of Death

2:20P

4a. Facility Name (If not institution, give street and number)

Vindobono Nursing Home

4b. City, Town, or Location of Death

Braddock Heights

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

216-38-6253

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

108

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Month, Day, Year
May 7, 1888

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

750 Carroll Parkway Apt. 4E

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jose Prudencio de Murguiondo

18. Mother's Name (First, Middle, Maiden Surname)

Emma Noma Howard

19a. Informant's Name/Relationship (Type, Print)

Maria Nomita von Barby Brady
granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5308 Burling Terrace Bethesda, MD 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

11/16

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

John O. Mitchell

22. Name and Address of Facility

Mitchell-Wiedefeld Home, Inc.
6500 York Rd.
Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Cerebral Vascular Accident

Approximate Interval Between Onset and Death

1 mo

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert S. Kaufmann, MD

29c. License number

D13971

29d. Date signed (Month, Day, Year)

November 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Kaufmann 300 West 9th Street Frederick Md

31. Date filed (Month, Day Year)

NOV 20 1996

32. Registrar's Signature

June Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505a.

To the Hospital/Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

1952

CHICAGO, ILL.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34972

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA RICHARDS

2. Date of Death

Nov. 12 96 11:15pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

BON Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-05-6166

6. Sex

1 ☐ M 2 ☒ F

7. Age (If yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 28, 1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1116 N. EDEN STREET

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

PRIVATE HOMES

17. Father's Name (First, Middle, Last)

BEVERLY W. RICHARD

18. Mother's Name (First, Middle, Maiden Surname)

ELLA HOLLAND

19a. Informant's Name/Relationship (Type, Print)

RUTH O. DANGERFIELD-SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1116 N. EDEN STREET BALTO, MD. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

11/18/96

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Calvin B. Scruggs, Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON STREET BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis shock

Due to (or as a consequence of):

sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicida 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D43351

29d. Date signed (Month, Day, Year)

11/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kechi Fred OKWARA 4000 W Northern Parkway MD 21215

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

510

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

1911

1912

1913

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34973

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRIETT S. SHEETS

2. Date of Death

November 18 1996

3. Time of Death

06:35pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-34-9522

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 6, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1200 Halstead Road

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Walter P. Sinclair

18. Mother's Name (First, Middle, Maiden Surname)

Irene B. Segrist

19a. Informant's Name/Relationship (Type, Print)

Mr. James B. Sheets, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 Halstead Road Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

11/21/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage Renal disease,
Diabetes Mellitus, Status post CVA
morbidly obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of an examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Adriana Andrade, MD

29c. License number

P10579

29d. Date signed (Month, Day, Year)

November 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adriana Andrade, 5601 Loch Raven Boulevard, Baltimore, Maryland, 21239

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

Jung Darden

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 9028.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34974

Film G741 item 5 per FH 11-27-96 rja

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
William R. Shockley | | 2. Date of Death
Month 11 Day 17 Year 96 | | 3. Time of Death
6:55 AM | |
| 4a. Facility Name (If not institution, give street and number)
Potomac Valley Nursing Home | | 4b. City, Town, or Location of Death
Rockville MD | | 4c. County of Death
Montgomery | |
| 5. Social Security
219-01-932494
279-01-4324 | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 26 1910 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD. | | 10b. County
Montgomery | |
| 10c. City, Town or Location
Rockville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
1235 Potomac Valley Rd. | | 10f. Zip Code
20850 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Painter | |
| 16b. Kind of Business/Industry
American Totalisator | | 17. Father's Name (First, Middle, Last)
David A. Shockley | | 18. Mother's Name (First, Middle, Maiden Surname)
Leona Caulk | |
| 19a. Informant's Name/Relationship (Type, Print)
Ruth Stephenson/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
947 Fairmount Ave. Towson, Md. 21204 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Cemetery | | 20c. Location - City or Town, State
11-22-96 Timonium, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | |
|--|--|--|--|
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Acute Myocardial INFARCTION
Due to (or as a consequence of):
Arteriosclerotic Heart Disease
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Alzheimer's Disease
Pneumonia
Renal Insufficiency | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Disease
Pneumonia
Renal Insufficiency | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
11-17-96 | |
| 28b. Time of Injury
M | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Rockville MD | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
20853 | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D 21662 MD | |
| 29d. Date signed (Month, Day, Year)
11-17-96 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wilhelmina S. CARINA MD
Rockville MD | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | |

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Am. U.S. Gov.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34975

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|---|--|---------------------------------|--|--|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eva B. Stubbs | | | | 2. Date of Death
Month November Day 12 , Year 1996 | | 3. Time of Death
1:57pm | | | | |
| | 4a. Facility Name (If not institution, give street and number)
1320 Sulphur Spring Road | | | | 4b. City, Town, or Location of Death
Arbutus | | 4c. County of Death
Baltimore | | | | |
| Funeral
Director | 5. Social Security Number
214-18-6580 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 23, 1921 | | | | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Arbutus | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
1320 Sulphur Spring Road | | | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
United States | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collegia (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Balto. Co. Schools | | | | | | |
| | 17. Father's Name (First, Middle, Last)
John Weber | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Johanna Albers | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
Richard H. Stubbs, husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1320 Sulphur Spring Road Arbutus, MD 21227 | | | | | | |
| | 20e. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park | | 20c. Location - City or Town, State
11/15/96 Woodlawn, Maryland | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Road
Arbutus 21227 | | | | | | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic small cell cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
2 1/2 months | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | |
| | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
D40850 | | | |
| | | | | 29d. Date signed (Month, Day, Year)
November 13, 1996 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YVONNE OTTAVIANO MD 900 CATON AVE BALTIMORE MD 21229 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34976

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLA MARIE SMITH

2. Date of Death
Month Day Year

November 17, 1996

3. Time of Death

2:00P.M.

4a. Facility Name (If not institution, give street and number)

Roland Park Place

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-24-0314

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 11, 1903

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

830 W. 40th. Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+ years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Principle/School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

William Franklin Smith

18. Mother's Name (First, Middle, Maiden Surname)

Rose Marie Erich

19a. Informant's Name/Relationship (Type, Print)

Virginia Swanson (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8754 Beacon St. Ft. Myers, Florida 33907

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

11-19

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure
Due to (or as a consequence of):b. Valvular Heart Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37133

29d. Date signed (Month, Day, Year)

11/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 Osler Drive Suite 209 Towson, MD 21204

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34977

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard J. Scruggs | | | | 2. Date of Death
Month November Day 4 Year 1996 | | 3. Time of Death
8:25 PM | |
| | 4a. Facility Name (If not Institution, give street and number)
CHURCH HOME HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-36-1680 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
54 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAR. 8 .1942 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
917 PAYSON STREET | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10TH
College (1-4or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MINISTER | | 16b. Kind of Business/Industry
CHURCH | | | |
| | 17. Father's Name (First, Middle, Last)
WELFORD J. SCRUGGS | | | | 18. Mother's Name (First, Middle, Maiden Sumame)
SALLIE J. BUTTS | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
CAROL SCRUGGS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
917 PAYSON STREET BALTO, MD. 21217 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cem. | | 20c. Location - City or Town, State
Balto, Md. | | 20d. Date
11-27-96 | |
| | 21. Signature of Funeral Service Licensee
Calvin B. Scruggs Sr. | | | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON STREET BALTO, MD. 21213 | | | |
| | 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. BRADYCARDIA
Due to (or as a consequence of):
b. ACIDOSIS
Due to (or as a consequence of):
c. RENAL FAILURE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death
30 min
hrs
months | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
INSULIN DEPENDENT DIABETES MELLITUS,
HYPERTENSION, ARTERIOSCLEROTIC CARDIO-
VASCULAR DISEASE | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
Paul Gormley MD | | | | 29c. License number
D18587 | | 29d. Date signed (Month, Day, Year)
NOV 20 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL GORMLEY 100 N. BROADWAY BALTO. MD 21231 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
June Davidson-Rendell | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

2000

2210 S. Voss

11/20/96 t.t


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34978

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedant's Name (First, Middle, Last)
Kenneth Sheppard | | | | 2. Date of Death
Month November Day 10 Year 1996 | | 3. Time of Death
1:21 am | |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-88-7787 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
33 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT 21, 1963 | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTO. | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
946 N. ROSEDALE ST | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LIMO DRIVER | | 16b. Kind of Business/Industry
LIMO CO | |
| | 17. Father's Name (First, Middle, Last)
JAMES SHEPPARD | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BLANCH POWELL | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
BLANCH SHEPPARD/MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
946 ROSEDALE ST BALTO, MD 21216 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT ZION CEM | | 20c. Location - City or Town, State
BALTO, MD | | 20d. Date
NOV 14 1996 | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
PARKER FUNERAL HOME
3512 FREDERICK AVE. BALTO, MD 21229
1129 N. CAROLINE ST BALTO, MD 21213 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

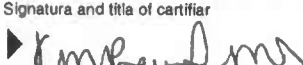
a. <u>Sepsis</u>
Due to (or as a consequence of):

b. <u>Liver failure</u>
Due to (or as a consequence of):

c. <u>Pericardial Tamponade</u>
Due to (or as a consequence of):

d. <u>End Stage Renal Disease</u>

Approximate Interval Between Onset and Death

48 hours
48 hours
48 hours
8 years | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Sickle cell | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 4 | 29b. Signature and title of certifier
 | | | | 29c. License number
96012 | | 29d. Date signed (Month, Day, Year)
November 11, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Preucil
Johns Hopkins Bayview Medical Center
4940 Eastern Avenue, Baltimore, MD 21224 | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34979

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MORRIS SHOR | | | | 2. Date of Death
Month Day Year
NOVEMBER 12, 1996 | | 3. Time of Death
0958 AM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
216-05-0435 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
APR. 20, 1913 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
37 STONEHENGE CIR., APT. 2 | | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CPA | | | 16b. Kind of Business/Industry
ACCOUNTING | |
| 17. Father's Name (First, Middle, Last)
JOSEPH L SHOR | | | | 18. Mother's Name (First, Middle, Maiden Summa)
SARA LEAH STUL | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MRS. EVELYN SHOR (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
37 STONEHENGE CIR., APT. 2 BALTO., MD 21208 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH EL MEM. PARK | | Date
11/14/1996 | | 20c. Location - City or Town, State
RANDALLSTOWN, MD |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION | | | | | | | | 1 HOUR |
| Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE | | | | | | | | YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. HYPERTENSION | | | | | | | | YEARS |
| Due to (or as a consequence of):
d. DIABETES MELLITUS | | | | | | | | YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
D 47587 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 12, 1996 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT FINE, M.D. NORTHWEST HOSPITAL CENTER | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

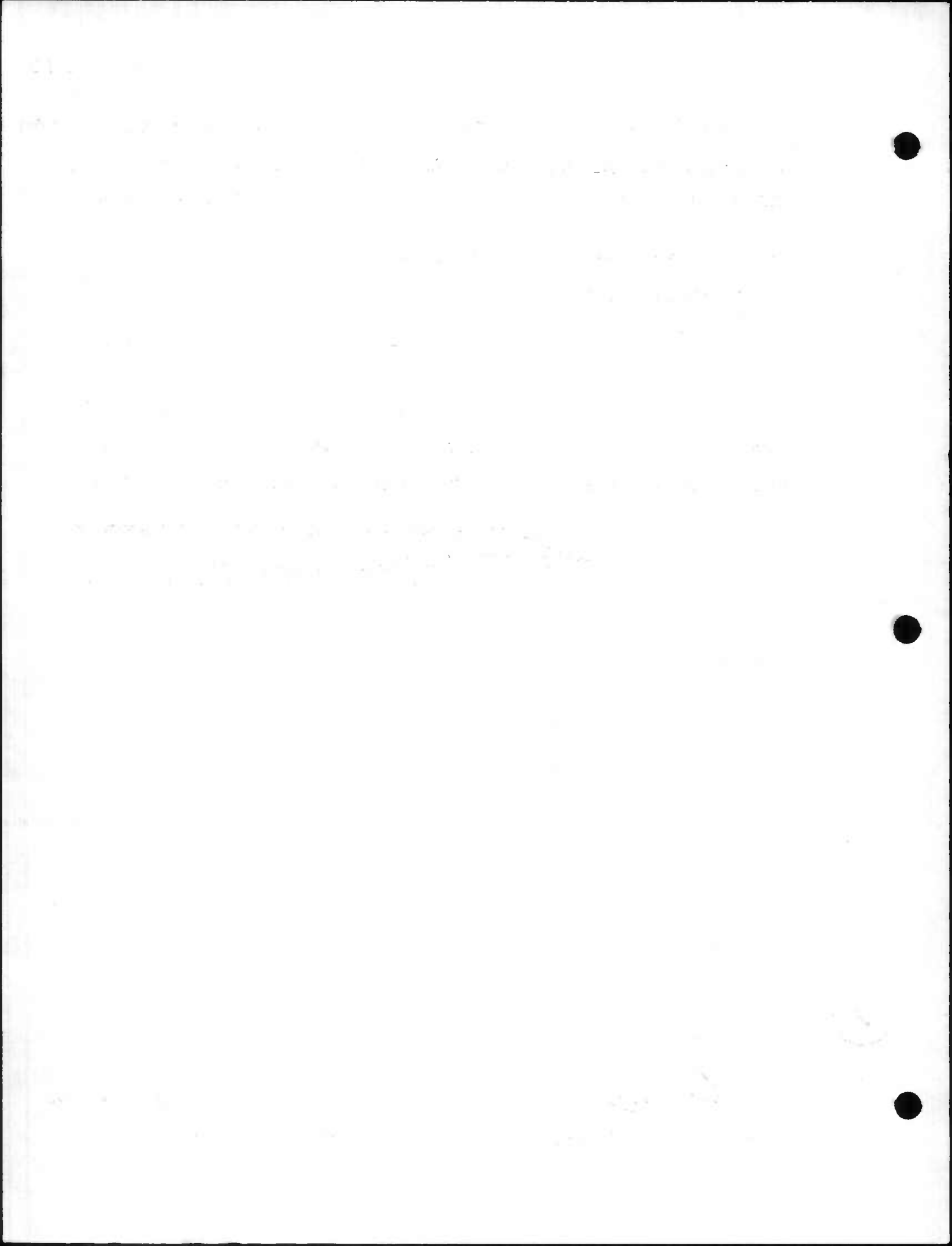
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 34980

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JONATHAN STREET

2. Date of Death

NOVEMBER 13, 1996

3. Time of Death

5:32 PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-62-4585

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 18, 1953

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND10b. County
N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1411 E. FEDERAL STREET

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10THCollege (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

SUMMER CORP.

17. Father's Name (First, Middle, Last)

JAMES WILSON

18. Mother's Name (First, Middle, Maiden Surname)

LUWANA JOHNSON

19a. Informant's Name/Relationship (Type, Print)

LUWANA CHAMBERLAIN- MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1600 E. CHASE STREET BALTO, MD. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. ZION CEMETERY

Date

nov. 19, 1996

20c. Location - City or Town, State

BALTO, MD.

21. Signature of Funeral Service Licensee

Calvin B. Scruggs Sr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

ONE WEEK

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ACQUIRED IMMUNODEFICIENCY SYNDROME

Due to (or as a consequence of):

FIVE YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LUNG FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Calvin B. Scruggs Sr. MD

29c. License number

047287/RES-000

29d. Date signed (Month, Day, Year)

11/14/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1830 EAST MONUMENT STREET SUITE 9020 BALTIMORE, MD 21205

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Signature of Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

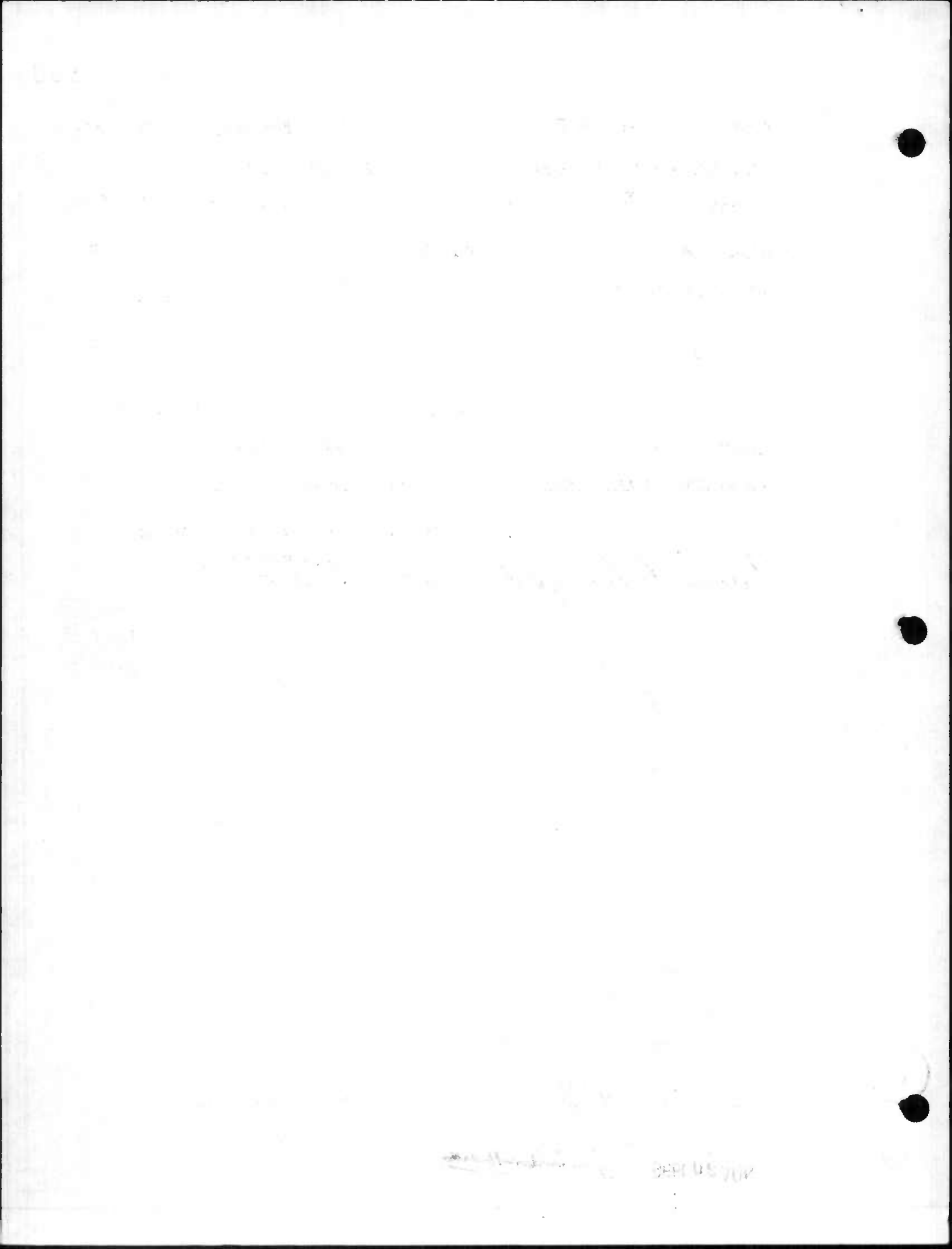
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34981

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNE SHERMAN | | | | 2. Date of Death
Month Nov Day 14 Year 96 | | 3. Time of Death
7:09 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
HURWITZ HOUSE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
214-54-6760 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCT. 2, 1905 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
135 SLADE AVE. | | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) HOMEMAKER | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
OWN HOME | | 16b. Kind of Business/Industry | | | |
| 17. Father's Name (First, Middle, Last)
UNKNOWN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DAVID LONDON (GRANDSON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
126 ROYALTY CIRCLE OWINGS MILLS, MD 21117 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SHAAREI TFILOH | | Date
11/15/96 | | 20c. Location - City or Town, State
BALTIMORE, MD | | | |
| 21. Signature of Funeral Service Licensee
<i>Scott M. Cutler</i> | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ASCVD
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate interval between Onset and Death
YES
YES | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>John Davidson-Randell</i> | | 29c. License number
D20333 | | 29d. Date signed (Month, Day, Year)
11/14/96 | |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)
1838 GALENTHE RD PIKESVILLE MD 21208 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | 32. Registrar's Signature
<i>John Davidson-Randell</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5055.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34982

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LENORA THOMAS

2. Date of Death

Month
NOV.

Day

19,

Year

1996

3. Time of Death

9:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

11711 LIVINGSTON ROAD

Fort Washington Hospital

4b. City, Town, or Location of Death

FORTWASHINGTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

577-28-4951

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year

May 27, 1911

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7103 Donnell Place #C6

10f. Zip Code

20747

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Dept Store

17. Father's Name (First, Middle, Last)

Robert Stother Strother

18. Mother's Name (First, Middle, Maiden Surname)

Blondena Bolden

19a. Informant's Name/Relationship (Type, Print)

Mary Louise Cheek-Step

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7103 Donnell Pl. #C6 Forestville, Md. 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cem.

Date

9/6

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Robert B. Baker

22. Name and Address of Facility

Chinn Funeral Service
2605 S. Shirlington Rd. Arl. Va. 22206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Approximate Interval Between Onset and Death

2 DAYS

Due to (or as a consequence of):

b. ISCHEMIC

2 DAYS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip Wisotsky

29c. License number

D18545

29d. Date signed (Month, Day, Year)

NOVEMBER 19, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PHILIP WISOTSKY, MD 11701 LIVINGSTON RD #203 ft washington, md 20744

31. Date filed (Month, Day, Year)

NOV 20 1996

32. Registrar's Signature

Julia Harrison

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34983

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BESSIE LEE TURNER

2. Date of Death

Month Day Year
NOVEMBER 16, 1996

3. Time of Death

8:30 A.M.

4a. Facility Name (If not institution, give street and number)

5112 CORDELIA AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-20-9018

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
JUNE 21, 1925

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State
MARYLAND10b. County
N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5112 Cordelia Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Self - Employed

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Ora L. Jones

19a. Informant's Name/Relationship (Type, Print)

Henry Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8213 Parham Court, Severn, Maryland 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

11-21-96 BALTIMORE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVENUE, BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

MYOCARDIAL

INFARCTION

b.

Due to (or as a consequence of):

CORONARY ARTERY DIS

c.

Due to (or as a consequence of):

HYPERTENSION

d.

Due to (or as a consequence of):

ARTERIOSCLEROTIC VASC DIS

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

VARICOSE VEINS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D00516

29d. Date signed (Month, Day, Year)

11/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAME

31. Date filed (Month, Day, Year)

NOV 20 1996

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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NOV 20 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34984

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Aquinas Thompson | | | | 2. Date of Death
Month November Day 17 Year 1996 | | 3. Time of Death
7:35 a.m. | | |
| | 4a. Facility Name (If not institution, give street and number)
1736 Weston Avenue | | | | 4b. City, Town, or Location of Death
Parkville | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
553-20-6198 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 7, 1916 | | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Parkville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1736 Weston Avenue | | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1936-1940 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Gen Foreman | | 16b. Kind of Business/Industry
Aerospace | | | | |
| | 17. Father's Name (First, Middle, Last)
John J. Thompson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Genevieve Herbert | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Timothy A. Thompson (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2012 Wiltonwood Rd. Stevenson, Md. 21153 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Redeemer Cemetery | | 20c. Date
11/21/96 | | 20d. Location - City or Town, State
Baltimore Maryland | | |
| | 21. Signature of Funeral Service Licensee
Milton J. Knight Jr | | 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore, Maryland 21214 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.
metastatic prostate Ca
a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Colon Carcinoma | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
D33624 | | 29d. Date signed (Month, Day, Year)
11/19/96 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JOHN E. DOWNS, MD 7505 OSLER DR. STE 504, TOWSON, MD 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
[Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 96 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34985

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Katharine VanBibber | | 2. Date of Death
Month Nov. Day 12, Year 1996 | | 3. Time of Death
4:00A.M. |
| | 4a. Facility Name (If not institution, give street and number)
Fairhaven Health Care Center | | 4b. City, Town, or Location of Death
Sykesville | | 4c. County of Death
Carroll |
| Funeral
Director | 5. Social Security Number
212-32-2210 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth
(Month, Day, Year)
Dec. 8, 1902 | | 9. Birthplace (State or Foreign Country)
Md. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10e. State
Md. | 10b. County
Carroll | 10c. City, Town or Location
Sykesville | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
7200 Third Ave. | | 10f. Zip Code
21784 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) +5 College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Administrator | | 16b. Kind of Business/Industry
Private School | | |
| | 17. Father's Name (First, Middle, Last)
Armfield F. VanBibber | | 18. Mother's Name (First, Middle, Maiden Surname)
Rebecca M. VanBibber | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Fairhaven Center | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7200 Third Ave. Sykesville, Md. 21784 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation Service | | 20c. Location - City or Town, State
11/18/96 Hampstead, Md. |
| | 21. Signature of Funeral Service Licensee
Harry W. Haight | | 22. Name and Address of Facility
Haight Funeral Home
P.O.Box 195 Sykesville, Md. 21784 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death |
| | a. Sleep Apnea
Due to (or as a consequence of): | | | | 18 months |
| | b. Hypoventilation Syndrome
Due to (or as a consequence of): | | | | 18 months |
| | c. _____
Due to (or as a consequence of): | | | | |
| | d. _____
Due to (or as a consequence of): | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Sick Sinus Syndrome
Hypertension | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
W. H. Haight MD | | 29c. License number
D34849 | | 29d. Date signed (Month, Day, Year)
November 12, 1996 | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print)
1645 Liberty Road Eldersburg MD 21784 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

AL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34986

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|-------------------------------------|--|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Theodore James Wies, Sr. | | | | 2. Date of Death
Month November Day 18 , Year 1996 | | | | 3. Time of Death
11:48 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
746 Camberly Circle Unit B-8 | | | | 4b. City, Town, or Location of Death
Towson | | | | 4c. County of Death
Baltimore County | |
| Funeral
Director | 5. Social Security Number
216-09-1373 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
APR. 16, 1909 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent
10a. State Maryland 10b. County Baltimore County 10c. City, Town or Location Towson | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
746 Camberly Circle unit B-8 | | 10f. Zip Code
21204 | |
| To Be Completed by Funeral Director | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) Collega | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Barber | | 16b. Kind of Business/Industry
Barber Shop | |
| | 17. Father's Name (First, Middle, Last)
Stephan Grabarek | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Cecelia unknown | | 19a. Informant's Name/Relationship (Type, Print)
Mary M. Vandenberg/daughter | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Lovett Court, Timonium, Maryland 21093 | | | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial Gardens NOV. 21 | | 20c. Location - City or Town, State
Lutherville, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Mitchell-Wiedefeld Home, Inc.
6500 York Rd. Baltimore, Maryland 21212 | | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Emphysema
Due to (or as a consequence of):
b. Congestive Heart Failure
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
NOV 20 1996 | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
D-37362 | | 29d. Date signed (Month, Day, Year)
NOV. 19, 1996 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anthony Serafis, M.D. 1205 York Road, Lutherville, Maryland 21093 | | | | 31. Date filed (Month, Day, Year)
NOV 20 1996 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34987

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|---|---|---|--|----------------------------|-------|-----------------|-------|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Natalie Levinia White | | | | 2. Date of Death
Month Day Year
November 16, 1996 | | 3. Time of Death
2:30 P.M. | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
6303 Brook Avenue | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
212-05-1576 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 25, 1904 | | | | | | | | | | | |
| | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
6303 Brook Avenue | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
United States | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker | | 16b. Kind of Business/Industry
Own Home | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Joseph Unknown Adams | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Henrietta Unknown Unknown | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Joann P. Hacker / Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7807 Ardmore Avenue, Baltimore, Maryland 21234 | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. | | Data
11/19 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
6415 Belair Road
John C. Miller, Inc. Baltimore, Maryland-21206 | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Myocardial Infarct</td> <td>24 hrs</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. Coronary artery disease</td> <td>2 yrs</td> </tr> <tr> <td>c. Hypertension</td> <td>2 yrs</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarct | 24 hrs | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Coronary artery disease | 2 yrs | c. Hypertension | 2 yrs | d. | |
| | Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarct | 24 hrs | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Coronary artery disease | 2 yrs | | | | | | | | | | | | | | | | |
| | c. Hypertension | 2 yrs | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="2">23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td>24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
George Vranian MD | | | | 29c. License number
D37091 | | 29d. Date signed (Month, Day, Year)
11-18-96 | | | | | | | | | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
George Vranian MD 20 E. Eager St Baltimore MD 21202 | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

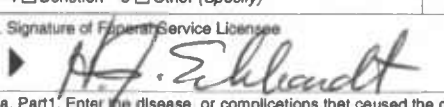
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34988

Certificate of Death

Reg. No.

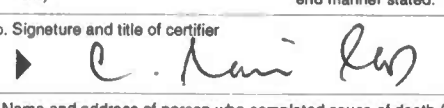
| | | | | | | | | |
|--|--|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JANIE Lee WAGNER | | | | 2. Date of Death
Month Day Year
NOVEMBER 19 1996 | | 3. Time of Death
0745 AM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
213-74-0879 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
104 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Mar. 7, 1892 | 9. Birthplace (State or Foreign Country)
Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Reisterstown | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
203 Northway Road | | | | 10f. Zip Code
21136 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Homemaker | | |
| 17. Father's Name (First, Middle, Last)
Samuel Coleman | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Laura Massey | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jane Heintzman | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
203 Northway Rd., Reisterstown, Md. 21136 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park Cem. Nov. 21, 1996 | | Date
Nov. 21, 1996 | | 20c. Location - City or Town, State
Woodlawn, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Eckhardt Funeral Chapel
11605 Reisterstown Rd., Owings Mills, Md. 21117 | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE CARDIO MYOPATHY
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D37333 | | 29d. Date signed (Month, Day, Year)
NOVEMBER 19, 1996 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
- C. NAVI MD, NHC, BALTO. MD 21133 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 20 1996 | | | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year.

3. The third part of the report deals with the financial statement of the year.

4. The fourth part of the report deals with the conclusions of the year.

96 34989

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HESTER G. YEATMAN | | | | 2. DATE OF DEATH
MONTH NOVEMBER DAY 16th YEAR 96 | | 3. TIME OF DEATH
4:10 P. M. | |
| 4. SOCIAL SECURITY NUMBER
215-44-8201 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
92 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
Aug. 14, 1904 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Genesis Lock Raven Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson | | 9c. COUNTY OF DEATH
Baltimore | |
| 10a. STATE
Md. | | | | 10b. COUNTY
City | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
2215 Louise Ave. | | | | 10f. ZIP CODE
21214 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) -12- | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
1 Yr. College Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Millard Yeatman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Clara Billingsley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Fay M. Gorsuch | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2215 Louise Ave. Baltimore, Md. 21214 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Carroll Cremation Service | | DATE
11/19/96 | | 20c. LOCATION — City or Town, State
Hampstead, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
ELINE FUNERAL HOME Reisterstown, Md. 21136 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Pneumonia | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. congestive Heart failure | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. coronary Artery disease | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | 29c. LICENSE NUMBER
D 30661 | | 29d. DATE SIGNED (Month, Day, Year)
NOVEMBER 18th 96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
8720 Emge Rd, Baltimore, Md - 21234 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 20 1996 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

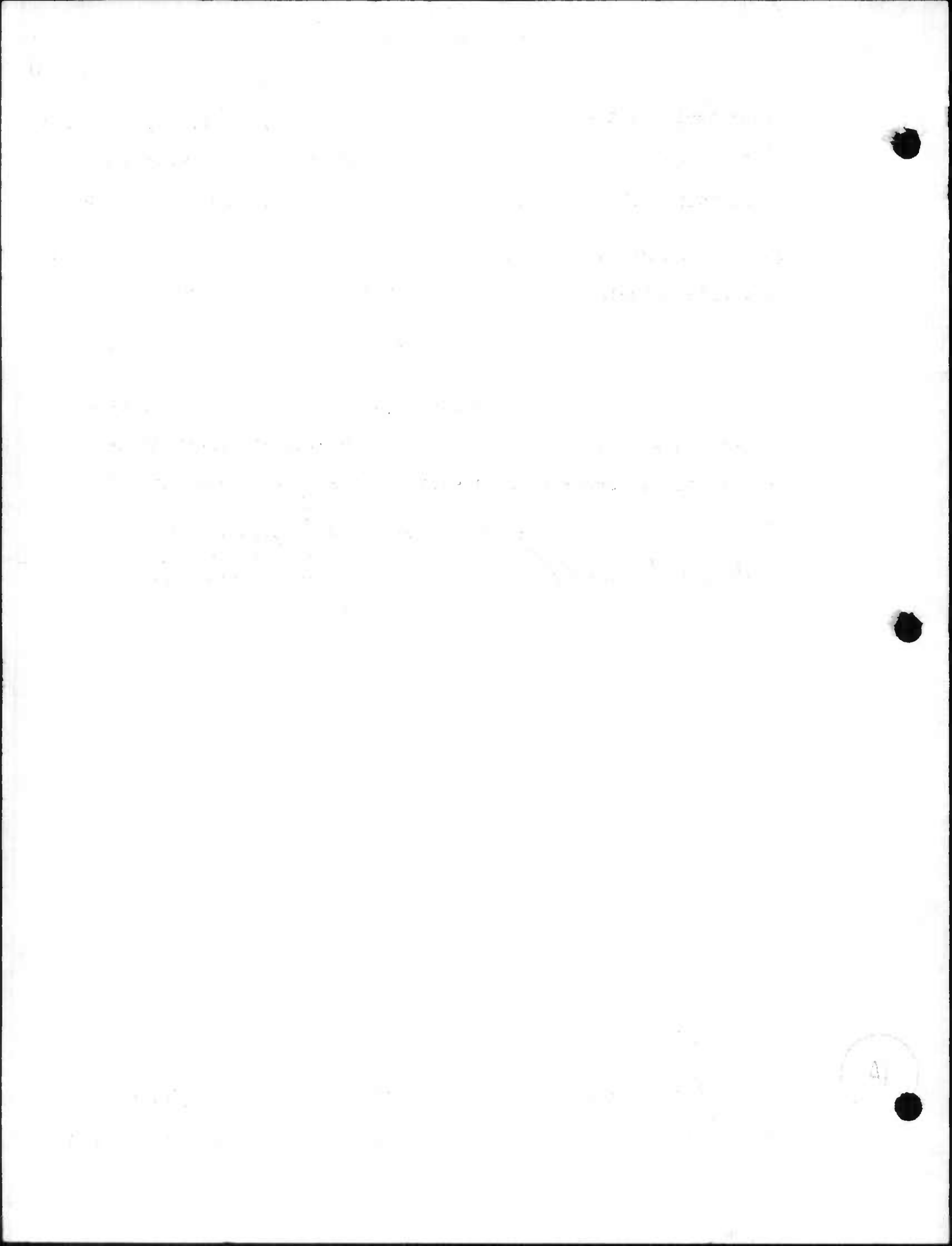
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 34990

Reg. No.

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34991

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM J. ANTKOWIAK

2. Date of Death

Nov. 8 96

3. Time of Death

3:00 P.M.

4a. Facility Name (If not institution, give street and number)

940 S. LAKEWOOD AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-10-7472

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAR. 10, 1921

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State
MD.10b. County
N/A10c. City, Town or Location
BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

940 S. LAKEWOOD AVE.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

TRUCKING

17. Father's Name (First, Middle, Last)

JOHN ANTKOWIAK

18. Mother's Name (First, Middle, Maiden Surname)

IDA NITKA

19a. Informant's Name/Relationship (Type, Print)

MARTHA ANTKOWIAK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1523 MEDFORD RD. BALTO., MD. 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

Nov. 11 1996

20c. Location - City or Town, State

BALTO. CO., MD.

21. Signature of Funeral Service Licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

SKARDA FAH.

2829 HUDSON ST.
BALTO., MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Cardiomyopathy - Congestive Heart Failure

Approximate Interval Between Onset and Death

yrs - days

b.

Due to (or as a consequence of):

Atrial Fibrillation

yrs

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Simon V. Scalia

29c. License number

D24216

29d. Date signed (Month, Day, Year)

11.11.96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Simon V. Scalia 2801 Hudson St.

31. Date filed (Month, Day, Year)

Nov 21 1996

32. Registrar's Signature

L. J. Hudson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34992

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHERINE PAPANIKOS ANGELAKOS

2. Date of Death

November 15, 1996

3. Time of Death

0530a

Funeral
Director

4a. Facility Name (If not institution, give street and number)

BERRY ROAD & BEALE HILL ROAD

4b. City, Town, or Location of Death

SUITLAND

4c. County of Death

PRINCE GEORGES

5. Social Security Number

322-76-8520

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

27 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAR 12, 1969

9. Birthplace (State or Foreign Country)

CHICAGO, ILL.

Usual Residence of Decedent

10a. State

MD.

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6145 SEA LION PLACE

10f. Zip Code

20603

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE ASST

16b. Kind of Business/Industry

ACCOUNTING FIRM

17. Father's Name (First, Middle, Last)

DEMETRIOS PAPANIKOS

18. Mother's Name (First, Middle, Maiden Surname)

THEODORA MOCHOS

19a. Informant's Name/Relationship (Type, Print)

JAMES ANGELAKOS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6145 SEA LION PLACE WALDORF, MD. 20603

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ELMWOOD CEM.

Date

NOV 18 1996 RIVER GROVE, ILL.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

SCENE

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

11-15-96

28b. Time of Injury

0149 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver - auto - auto collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Berry Rd & Beale Hill Rd

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 21 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34993

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Esther ASAFO-AGYEI

2. Date of Death

November 17, 1996

3. Time of Death

1:45 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

213-40-1518

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 19, 1941

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7404 D Meadowbranch Ct.

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Printer

16b. Kind of Business/Industry
Photo Electronic
Printing

17. Father's Name (First, Middle, Last)

Frank Victor Ceanfaglione

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Fanto

19a. Informant's Name/Relationship (Type, Print)

Frank Victor Ceanfaglione/father 3339 Woodside Ave. Parkville, MD 21234

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 11/18/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mary Eliaiguo

29c. License number

RD 02106

29d. Date signed (Month, Day, Year)

11/17/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Craig M.D. 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

NOV 21 1996

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

0271

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph document with various lines of text and possibly some small diagrams or tables interspersed.]

[Faint text lines follow, including what might be a list or series of entries.]

[Faint text lines follow, possibly a continuation of the list or a new section.]

[Faint text lines follow, possibly a concluding paragraph or a signature block.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, State of Maryland / Department of Health and Mental Hygiene
PER MEO FILM G-743 1/9/97 t.t. Items: 23 part I, per MEO G-746 4/1/97

96 34994

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedant's Name (First, Middle, Last)
TORI E. ATKINS | | 2. Date of Death
Month NOV. Day 16 Year 1996 | | 3. Time of Death
1707 PM |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL PEDIATRIC E.R. | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
213 47 7869 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs. 6 Months 29 | 8. Date of Birth (Month, Day, Year)
April 18, 1996 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10e. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore |
| | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
U.S. | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
N/A | | |
| | 17. Father's Name (First, Middle, Last)
Robert Atkins | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Jannie Mitchell | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Robert Atkins / father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
457 Lambert Court Baltimore, Maryland 21227 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestlawn Memorial Park | | 20c. Location - City or Town, State
11/19/96 Marriottsville, Md. |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
COARCTATION OF AORTA CARDIAC ARRHYTHMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
NOV 16 1996 | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
NOV. 17, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 21 1996 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34995

ITEM#4c PER F.H. FILM#G741 11/21/96 J.A. Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN BONSEIGNEUR

2. Date of Death

Month
NOVDay
19Year
1996

3. Time of Death

10:55 AM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A
BALTIMOREFuneral
Director

5. Social Security Number

215-10-9550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 20, 1897

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

442 Greenlow Road

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Elizabeth Ott

18. Mother's Name (First, Middle, Maiden Surname)

George Miller

19a. Informant's Name/Relationship (Type, Print)

Rita Hall (Granddaughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

442 Greenlow Road Catonsville, Maryland 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

The Most Holy Redeemer

Date

November 25, 1996

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.

1630 Edmondson Avenue Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

UROSEPSIS

Approximate Interval Between Onset and Death

4 DAYS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

MULTIINFARCT DEMENTIA

SEIZURES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MEERA RESIDENT

29c. License number

P.O. 9884

29d. Date signed (Month, Day, Year)

NOV. 19th, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARUN MEHRA, 900 CATON AVE., BALTIMORE, M.D. 21229.

31. Date filed (Month, Day, Year)

NOV 21 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 34996

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Beale

2. Date of Death

November 16 1996

3. Time of Death

10:44 PM

4a. Facility Name (If not institution, give street and number)

Greater Laurel Medical Center

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

577-52-3617

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 6, 1939

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6360 Tinted Hill

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lab Assistant

16b. Kind of Business/Industry

Walter Reed Hospital

17. Father's Name (First, Middle, Last)

Frank Beale

18. Mother's Name (First, Middle, Maiden Surname)

Lola Cannon

19a. Informant's Name/Relationship (Type, Print)

Mae Anna Beale (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6360 Tinted Hill Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbia Memorial Park Nov. 22, 1996

Data

20c. Location - City or Town, State

Columbia, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, Maryland 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction
Due to (or as a consequence of):b. Coronary artery disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour
10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles E Taylor MD 2 Knoll North Drive Columbia MD 21045

31. Date filed (Month, Day, Year)

NOV 21 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

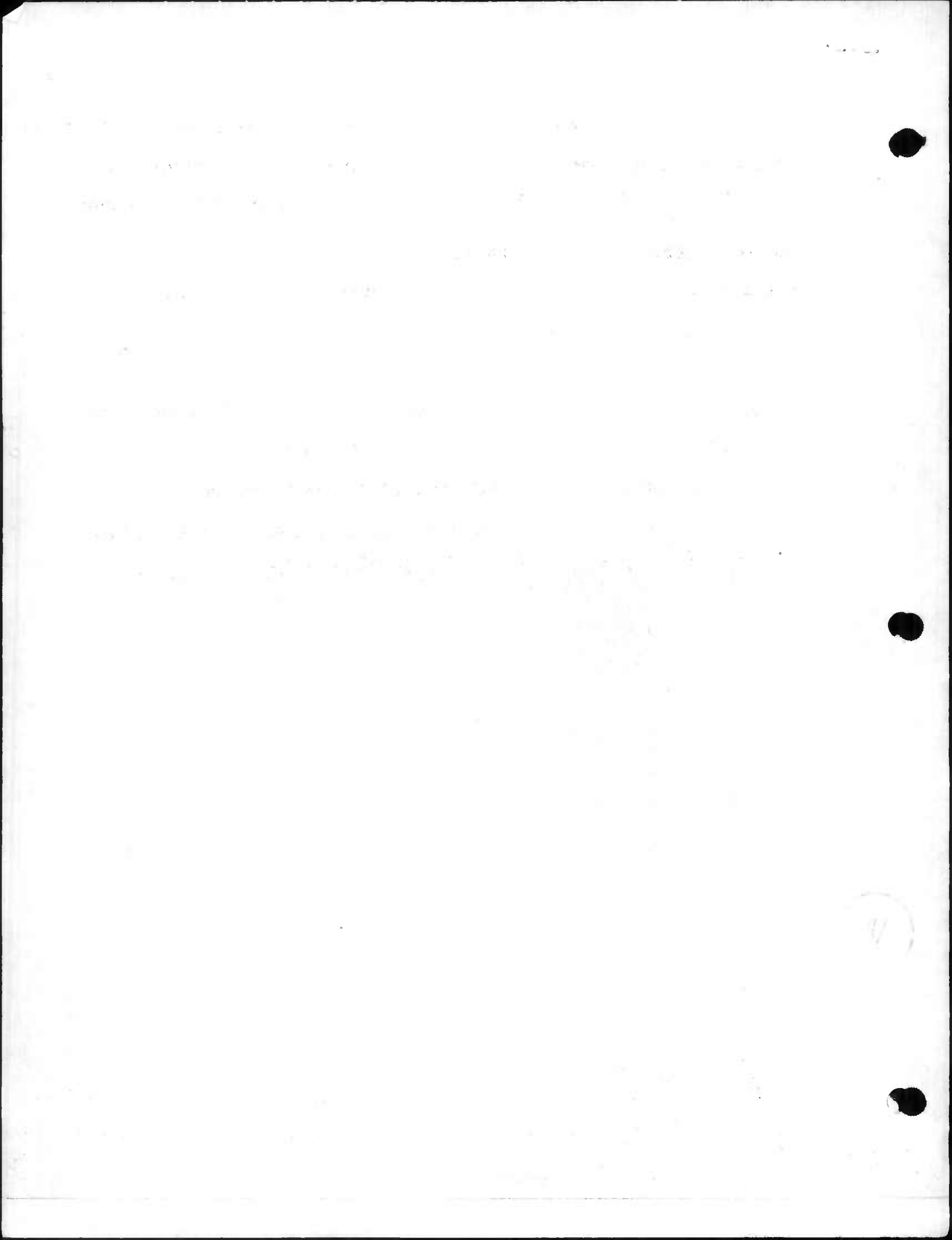
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 34997

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CONSTANCE BRUDER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
November 18, 1996 | | 3. TIME OF DEATH
2:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER
216-05-4634 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
September 14, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Bon Secour Nursing Care | | 9b. CITY, TOWN OR LOCATION OF DEATH
Ellicott City | |
| 9c. COUNTY OF DEATH
Howard | | | | 10a. STATE
Maryland | | 10b. COUNTY
Howard | |
| 10c. CITY, TOWN OR LOCATION
Ellicott City | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
3000 North Ridge Road | |
| 10f. ZIP CODE
21043 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Apolinary Ignatowski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ballbina Wagner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jenine Fitzgerald (Granddaughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
651 Windsor Drive Westminster, Maryland 21158 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Nov. Most Holy Redeemer Cemetery 21, 1996 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
RC, Wth | | | | 22. NAME AND ADDRESS OF FACILITY
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPTIC SHOCK Approximate Interval Between Onset and Death 7 DAYS | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST INFECTED DEBRITUS ULCERS 30 DAYS | | | | | | | |
| IMMOBILITY 12 MONTHS | | | | | | | |
| RECURRENT CEREBROVASCULAR ACCIDENTS 5 YEARS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
CONGESTIVE HEART FAILURE
DEMENCIA | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
David O. Nyantuma MD | | | | 29c. LICENSE NUMBER
D 36974 | | 29d. DATE SIGNED (Month, Day, Year)
11/18/96 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DAVID O. NYANTUMA MD
5999 HARPER'S FARM RD COLUMBIA MD 21044 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
NOV 21 1996 | | | | 32. REGISTRAR'S SIGNATURE
Jake Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-10-50

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 34998

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

J.W. Paulus Brandt

2. Date of Death

Month Day Year
Nov. 17, 1996

3. Time of Death

4:00 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

214-03-4311

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar. 15, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4207 Darleigh Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Retired

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Charles Franklin Brandt

18. Mother's Name (First, Middle, Maiden Surname)

Sofia Louise Hansen

19a. Informant's Name/Relationship (Type, Print)

Carol A. Breighner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 2365, R.D.#2, Spring Grove, Pa. 17362

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory 11-19-96 Beltsville, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton Funeral Home, Inc.

2134 Willow Spring Rd., Balto., Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Myocardial Infarction
Due to (or as a consequence of):

1 hour

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Venous stasis disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined26a. Date of Injury
(Month, Day Year)26b. Time of
Injury26c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL D. MARTIN, MD. 1576 Merritt Blvd. Baltimore, MD 21222

31. Date filed (Month, Day, Year)

NOV 21 1996

32. Registrar's Signature

John Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

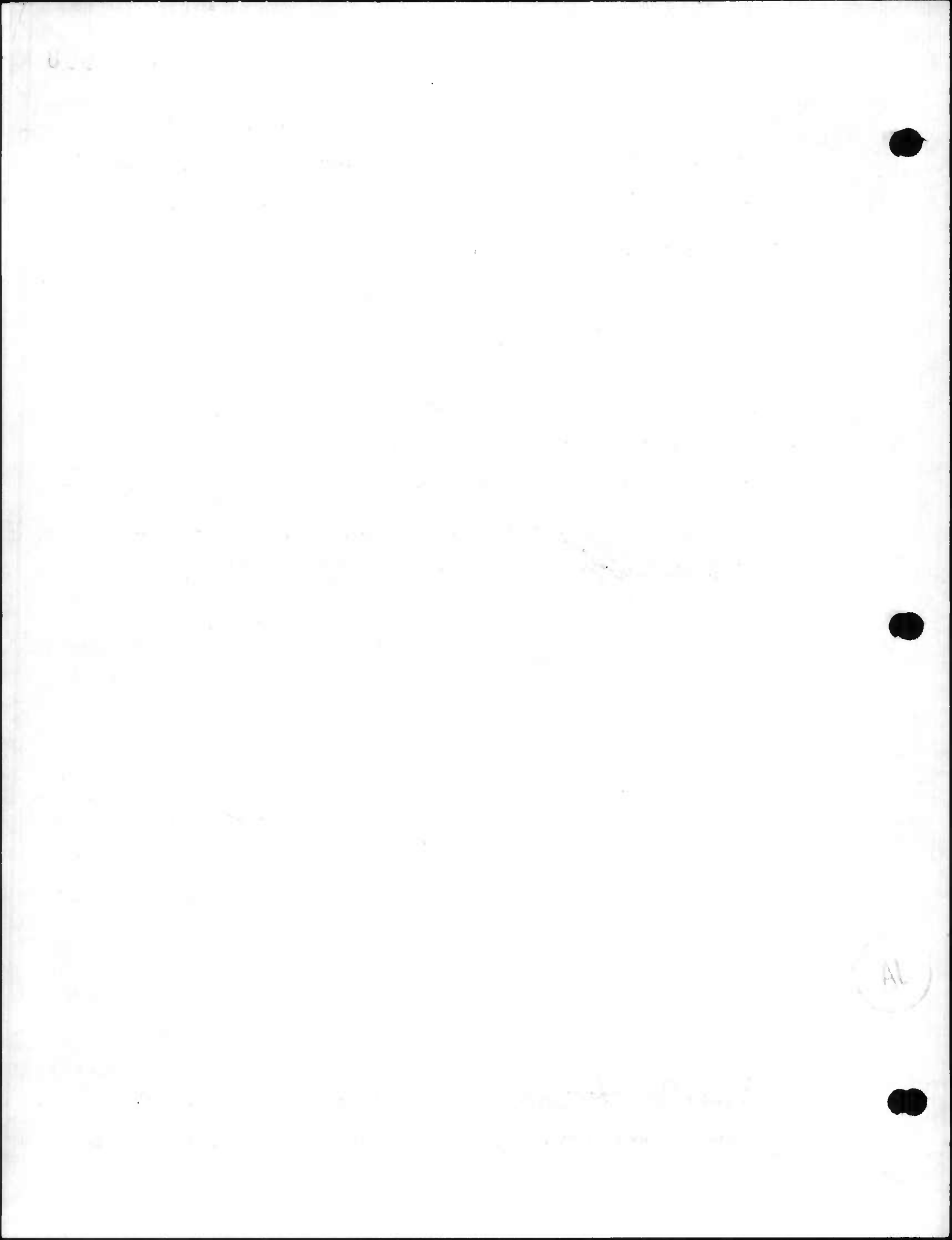
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 34999

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Maude Catherine Briele

2. Date of Death

November 19, 1996

3. Time of Death

6:40 A.M.

4e. Facility Name (If not institution, give street and number)

Homewood Nursing Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

220-07-7692

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 13, 1917

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inade City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5902 Brackenridge Ave.

10f. Zip Code

21212

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Wesley Akehurst

18. Mother's Name (First, Middle, Maiden Surname)

Grace Carpenter

19e. Informant's Name/Relationship (Type, Print)

Donna L. O'Laughlen (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5902 Brackenridge Ave. Baltimore, Md. 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

11/20/96

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

10 yrs.

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

breast cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jeffrey L. Gair

29c. License number

D28987

29d. Date signed (Month, Day, Year)

11-19-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL SPERLING, M.D. 3333 N. Calvert Street Baltimore, Md. 21218

31. Date filed (Month, Day, Year)

NOV 21 1996

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 35000

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
James Irvin Beard | | 2. Date of Death
Month November Day 16 Year 1996 | | 3. Time of Death
5:00PM | |
| 4a. Facility Name (If not institution, give street and number)
7611 Charlesmont Road | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore | |
| 5. Social Security Number
212-32-6604 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
Sept. 2, 1936 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
7611 Charlesmont Road | | 10f. Zip Code
21222 | |
| 10g. Citizen of What Country?
United States | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Food Preparation | | 16b. Kind of Business/Industry
Food Industry | |
| 17. Father's Name (First, Middle, Last)
Joseph Irvin Beard | | 18. Mother's Name (First, Middle, Maiden Surname)
Pearl Sweetman | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret S. Chamberlain/Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7611 Charlesmont Road Dundalk, Maryland 21222 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Faith Cem. | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Chronic obstructive pulmonary disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Carolyn C. Houk MD | | 29c. License number
9600 B | | 29d. Date signed (Month, Day, Year)
November 18, 1996 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
CAROLYN HOUK M.D. JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4940 EASTERN AVENUE BALTIMORE, MD 21224 | | | | | |
| 31. Date filed (Month, Day, Year)
NOV 21 1996 | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State
Registrar

